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(*Continuing the California State Journal of Medicine*)

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CALIFORNIA
AND
WESTERN MEDICINE

VOL. XXIII JANUARY, 1925 No. 1

SPECIAL ARTICLE

SOME PRACTICAL SUGGESTIONS REGARDING TESTIMONY OF MEDICAL EXPERTS *

By JUDGE PAUL BURKS, Los Angeles**

THIS SUBJECT IS ONE OF GROWING IMPORTANCE TO COURTS, PHYSICIANS, ATTORNEYS, AND PARTICULARLY TO THE PUBLIC, IN THE INTERESTS OF THE INTELLIGENT AND HUMANE ADMINISTRATION OF JUSTICE.

THE PRESENT INEFFICIENT LAWS AND CUSTOMS UNDER WHICH MEDICO-LEGAL PROCEDURE IS CARRIED ON IS ABLY AND INTERESTINGLY ANALYZED BY THE LATE JUDGE BURKS OF LOS ANGELES. THE AUTHOR'S PAPER IS ABLY DISCUSSED BY DOCTORS ANDREW STEWART LOBINGIER OF LOS ANGELES AND WILLIAM C. WOODWARD, EXECUTIVE SECRETARY OF THE BUREAU OF LEGAL MEDICINE AND LEGISLATION OF THE A. M. A.

WE HAVE NO HESITANCY IN URGING NOT ONLY PHYSICIANS, BUT ATTORNEYS TO READ AND PONDER THESE DISCUSSIONS IN THE INTEREST OF THE GOOD NAMES OF TWO GREAT PROFESSIONS AND OF INDIVIDUAL ATTORNEYS AND PHYSICIANS WHOSE REPUTATIONS, AND THE GENERAL WELFARE OF AN IMPORTANT AND NECESSARY SERVICE, NOW SUFFER BY UNFORTUNATE PROCEDURES.

WE COMMEND A CAREFUL STUDY OF THESE DISCUSSIONS TO THE JUDGES OF OUR COURTS, WITH THE HOPE THAT INTEREST MAY BE AROUSED THAT WILL LEAD TO IMPROVED LAWS AND IMPROVED SERVICE TO SOCIETY.

JUDGE BURKS SAYS THAT: "ANOTHER DESIRABLE METHOD OF OBTAINING EXPERT TESTIMONY WOULD BE TO HAVE THE TRIAL JUDGE APPOINT THREE WELL-QUALIFIED EXPERTS. ONE MIGHT BE APPOINTED AT THE SUGGESTION OF EACH PARTY, AND THE THIRD AT HIS OWN DIRECTION OR BY THE TWO THUS APPOINTED, AND THEN THESE THREE COULD BE REQUIRED TO HEAR ALL OF THE TESTIMONY AND PRIVATELY EXAMINE SUCH WITNESSES OR PARTIES, AND PRESENT TO THE COURT, IN WRITING, A REPORT WHICH, AS TO THE FACTS FOUND, WOULD BE BINDING UPON THE JURY. REMUNERATION FOR THIS SERVICE COULD BE DIVIDED BETWEEN THE PARTIES TO THE ACTION, OR TAXED AS COSTS AS ARE JURY FEES."

WHY NOT ARRANGE A CONFERENCE BETWEEN REPRESENTATIVES OF THE MEDICAL ASSOCIATION, BAR ASSOCIATION; THE JUDGES AND A FEW OTHER LEADING ORGANIZATIONS, AND MAKE A SERIOUS EFFORT TO BETTER A SITUATION THAT NOW REFLECTS UPON MANY ELEMENTS OF SOCIETY AND, THEREFORE, UPON CIVILIZATION AS A WHOLE?—EDITOR.

SUBJECT defined and elucidated.
Distinction between advocacy of a cause and establishment of facts clarified.
Dangers and troubles of present method discussed.
Methods for improvement suggested.
DISCUSSION *by Andrew Stewart Lobingier, M.D., Los Angeles, and William C. Woodward, Chicago.*

EXPERIENCES with which some of your members are familiar are, primarily, responsible for my having been requested to make some "practical suggestions" respecting testimony of medical experts in judicial proceedings. Nothing which may be said is to be construed as a criticism of your profession, or of any of its members. The honor which you have bestowed upon me is appreciated, and evokes in me a sincere desire to be of service to you.

This is the day of specialists. Experts of all kinds are called upon, with constantly increasing frequency, as witnesses in both civil and criminal cases to assist courts and juries in investigating and determining questions of fact relating to subjects with which men, ordinarily, are not familiar. In many cases which are now presented to courts and juries, the evidence of one or more expert witnesses becomes a factor of determining importance in efforts to reach just conclusions.

In the play of King Henry VI (Act IV, Scene II), Shakespeare puts into the mouth of Dick, the butcher, an expression which is so short and so pointed as to render pardonable its reproduction in its

* Read before General Session of the Fifty-third Annual Session of California Medical Association, Los Angeles, May 15, 1924.

** We regret to announce the death of Judge Burks on October 9, 1924.

completeness. It reads: "The first thing we do, let's kill all the lawyers." The circumstance under which those of your profession are likely to re-echo this sentiment is when you leave the witness-stand, after having served as a medical expert.

Efforts to confound you which, too frequently, are put forth by lawyers inexperienced in trial work are amusing, and usually serve only to make the confusion of your ready terminology worse confounded. On those rare cases, however, when you are subjected to what our newspaper friends term "a gruelling cross-examination" by one skilled and experienced in the well-nigh-lost art of cross-examination and able to pierce your armor of technical expressions, then, friends, oh! then someone is apt to emerge from the fray resembling the proverbial "two-bits plus carfare."

HISTORY OF MEDICAL JURISPRUDENCE

One of the best definitions of "medical jurisprudence" to be found is that of Dr. T. R. Breck, one of its early and most eminent cultivators. He refers to it as:

"That *science* which applies the principles and practice of the different branches of medicine to the elucidation of doubtful questions in courts of justice."

The different branches alluded to in this old definition, doubtless, are chemistry, anatomy, physiology, pathology, etiology, hygiene and the practice of medicine, surgery and midwifery. To these there must, of course, now be added toxicology, psychology, roentgenology, and other specialties as they develop.

Not until the fifteenth century did the actual, practical study of analytical chemistry and of human anatomy progress far enough to impart to each of these departments of knowledge the character or dignity of a distinct branch of medical science.

In the history of the Jews, the Egyptians and the early Romans, are found items that may with fairness be said to belong to the domain of medical jurisprudence. Not, however, until the Code of Laws promulgated by George, Bishop of Bamberg, in 1507 and, more fully, in the "Caroline" Code by Emperor Charles V of Germany in 1552, do we find any real recognition by the law of the value of medical facts in legal proceedings. This code contained the first provision requiring medical men to appear in court as witnesses, and directed that their opinion should be taken in cases where death was alleged to have occurred by violence and suspicion of a criminal agency existed.

The nucleus from which sprang the French system of medical jurisprudence was the order of King Henry in 1606, requiring his chief surgeon to designate, in each large city or town, two surgeons who were required to examine and report on all wounded or murdered persons. At about the same time we begin to find in England recorded instances of the employment of medical witnesses in criminal trials.

In the trial for the murder of Jane Norkett in 1628, a body was disinterred for a second inquest thirty days after the first inquest had been held. The Coroner's jury at the first inquest returned a verdict of suicide. It was shown upon the trial that, when Jane Norkett's body was disinterred for the second inquest, one of the persons accused of her murder touched the body, "whereupon the brow of the dead, which before was of a livid and carrion color, began to have a dew or gentle sweat arise on it which increased by degrees until the sweat ran down in drops on the face, the brow turned to a lively and fresh color and the deceased opened one of her eyes and shut it again; and this opening of the eye was done several times; she likewise thrust out the ring or marriage finger several times and pulled it in again, and the finger dropped blood on the grave."

The earliest works on medical jurisprudence worthy of special mention are those of Fidelis of Italy in 1598; Zaechus in 1621; Ambrose Paré, 1630; Deveaux, 1693; Bohn, 1702; and Fodere in 1796. During the seventeenth and eighteenth centuries a limited amount of instruction in medical jurisprudence seems to have been given in the Medical School of Edinburgh and in some of those on the continent of Europe.

The medical department of Columbia College of New York is entitled to the credit of establishing, in 1804, the first full professorship of medical jurisprudence in America, which was filled with much ability for many years by Dr. J. S. Stringham. Similar chairs were established in Louisville Medical College in 1812, occupied by Dr. Charles Caldwell; in the College of Physicians and Surgeons for the Western District of New York in 1815, filled by Dr. T. Romeyne Beck, and in Harvard Medical School in 1816, filled by Dr. Walter Channing; since then this branch has become recognized as a necessary part of the curriculum of all the more important medical schools, both in this country and in Europe.

Few, if any, state boards of medical examiners will now recognize as in good standing any institution which omits full instruction in this important branch. This is eminently proper when we consider that every practitioner of medicine is liable at any time to be hailed into court to give strictly medical testimony necessary, not only for the detection of crimes and the decision of questions of mental capacity, but also bearing on the public health of the various activities and industries of society and concerning the nature, extent and probable consequences of constantly recurring personal injuries which, in spite of all laws enacted and devices invented and rules of conduct promulgated, increase in frequency with the development of modern methods of travel, trade, and industry.

VALUE OF MEDICAL JURISPRUDENCE

The value of the application of chemical processes in detecting and determining the nature of poisons in cases of homicide and suicide, and in detecting adulterations and impurities in air, water, food products and drinks, for the prevention of frauds and for the protection of public health; the application of a thorough knowledge of anatomy and physiology as an aid in determining the nature, extent and probable consequences of wounds and personal injuries, whether homicidal, suicidal, or accidental; the application of the facts and principles constituting the physiology and pathology of the brain in the determination of questions regarding

mental competency, idiocy, and insanity are all so frequent and so generally acknowledged as to render unnecessary any illustrations of their incalculable worth and frequent use.

All concede the great value to men of your profession of a thorough knowledge of medical jurisprudence because upon *you* devolves the responsibility of occupying the witness-stand and imparting such facts and opinions as may enlighten courts and juries and facilitate the administration of justice. The equal importance, however, of the study of medical jurisprudence by lawyers and students of the law has been too long overlooked.

The lawyer does not find it necessary to go upon the stand in an effort to impart valuable medical knowledge to the court and jury. For that reason, he is apt to feel it unnecessary to master all the details of chemical analysis, causes of mental and physical diseases, and the probable consequences of acts of personal injury. He forgets that the important responsibility of deciding when, and what kind of, medical evidence is required in a given case rests upon him and that upon him devolves the work of eliciting such evidence from medical expert witnesses in such a manner as to insure its being understood by the court and by the jury. If he has not at least as much medical knowledge as is contained in our best works on medical jurisprudence, it is utterly impossible for a lawyer accurately to know the kind of medical expert testimony essential to proper enlightenment as to how so to frame his questions as to elicit from them those facts and opinions which are necessary to attain the ends of substantial justice and to avoid subjecting both himself and his witness to humiliation and embarrassment.

The average lawyer is poorly equipped to cope with the medical expert in his own field of inquiry because his research of medical authorities is rarely such as to fit him to undertake a task always delicate and often dangerous. Few attorneys are capable of examining medical experts. Fewer still are there who, should it become necessary, are capable of discrediting, with a jury, a well-informed witness of this kind. Any extended cross-examination along the line of such expert's theory, unless conducted with the utmost skill and assurance, is apt to prove disastrous by affording an opportunity for enlargement upon testimony already given and explanation of that which may have been overlooked or misunderstood by the jurors.

CAUSES OF DISSATISFACTION

As soon as the testimony of medical experts was recognized by the law, doctors commenced to disagree. As far back as the early part of the eighteenth century, we find reflections upon the merits of this kind of evidence equally as frank and outspoken as those frequently made by the bench, bar, and newspapers of today. An example of the contempt for expert testimony so often expressed by modern judges is found in the charge to the jury in the trial of Spencer Cowper, an Englishman of high position charged with the murder of Sarah Stout, a Quakeress, whose body was found one morning in a millstream. The evidence showed that Cowper was last seen with her the night before. The medical questions involved were most emphatically controverted by physicians on both sides, and Baron Hatsell, presiding, said:

"You have also heard what the doctors and surgeons said on the one side and the other concerning the swimming and sinking of dead bodies in the water; but I can find no certainty in it, and I leave it to your consideration. The doctors and surgeons have talked a great deal to this purpose and of the water going into the lungs or thorax; but unless you have more skill in anatomy than I you will not be much edified by it."

Some years later we find in the records of another criminal trial what must have been an early case of the now all-too-common defense of "brainstorm." In this case the curious result of the denial to the prisoner of the assistance of counsel in trials for felony was that Lord Ferrers, who was being tried, set up insanity as a defense and was obliged himself to examine the witnesses called in support of his plea.

There is probably no class of expert witness who is so prone to overindulge in a pedantic use of technicalities as is the physician or surgeon. This doubtless is due to the nature of his science. It is particularly true of the younger members of your profession. In an early report of a case of assault, a house surgeon testified:

"I discovered considerable ecchymosis under the left orbit, caused by extravasation of blood beneath the cuticle."

Baron Bramwell—"I suppose you mean the man had a black eye."

Scientific Witness—"Precisely, my lord."

Baron Bramwell—"Perhaps if you had said so in plain Enlish these gentlemen would better understand you."

"Precisely, my lord," answered the learned surgeon, evidently delighted that the judge understood his meaning.

The foregoing would have been worthy of the young practitioner who described a suppression of perspiration as "an agglutination of the sebaceous follicles."

Tendencies thus indicated have shown some improvement. Instances, however, are still frequent where a medical expert—particularly if he is testifying before a jury—indulges in the use of technical and other expressions which the lay mind cannot possibly comprehend. The result is that court, counsel, and jury not only lose interest and fail utterly to comprehend what is being said, but also at times are made positively weary. The use of plain and equally effective words would have an opposite effect, would command interest and respect and promote the ends of justice.

In a recent case it became important to determine the length of plaintiff's leg as bearing upon the extent of personal injuries for which damages were sought. Defendant's counsel, upon cross-examination, asked plaintiff's medical expert from what point he had made the measurement to which he had previously testified. In the language of his calling, the expert replied: "From the anterior superior spinal process of the ilium." "A-h-h! My God!" exclaimed the attorney, overpowered by a jargon more mysterious than his own. After further ex-

amination, he succeeded in eliciting the fact that the place with the name "of learned strength and thundering sound" was the small point of bone on the side of the hip that can be felt with the fingers.

Experts of every kind have pet systems and theories by which they are prone to solve knotty questions presented to their art or science. They often do this in perfect innocence unless restrained by the watchfulness of court and counsel. Medical experts, unfortunately, are not exempt from this temptation and, under the prevailing custom, "with medical questions more doubtful, perplexing and complicated than the legal issue on trial, with masses of testimony confused and contradictory, a number of medical men in a cloud as to what has been proved and what has not, two or more lawyers who do not understand the physicians, it is not reasonable to expect that a jury, however sensible, could evolve order out of such chaos." It is not surprising that there should exist a growing desire not only among doctors and surgeons, but also among lawyers and judges to reform an altogether unsatisfactory condition.

After an experience of a lifetime at the bar and on the bench, the final judgment of Judge Campbell was that:

"Skilled witnesses come with such a bias on their minds to support the course on which they are embarked that hardly any weight should be given to their evidence."

Taylor, in his treatise on the "Law of Evidence," emphatically declares:

"Expert witnesses become so warped in their judgment by regarding the subject in one point of view, that, even when conscientiously disposed, *they are incapable* of expressing a candid opinion."

The unforunate fact is that these opinions are so generally entertained and so often justified. Important cases frequently arise, however, in which the testimony of such witnesses must be reckoned with. It is now quite generally understood among lawyers that it is only by an ability properly to examine expert witnesses that jurors can be enlightened and enabled to arrive at a just estimate of the value of such testimony.

Much of the dissatisfaction with expert testimony, more especially that of medical experts, is due not so much to lack of honesty or candor in men of your profession as to the utter inability of lawyers properly to examine such witnesses or to appreciate the merits or demerits of statements which are honestly made, but clothed in words not easily understood by untrained ears.

We all know that honest opinions of different experts can be obtained upon opposite sides of the same question and that dishonest opinions may be obtained upon different sides of the same question. There is, however, a clear and clean-cut distinction between matters of scientific fact and mere matters of opinion.

When medical experts are called upon to establish certain facts which are not matters of opinion, it should be practically impossible for them to disagree.

When it comes to the province of mere opinion we know too well that these same experts differ among themselves to an extent which causes but little credit to be given to mere expert opinions as such, whereas under any proper system they should be received with the utmost confidence.

The "medical expert" should, and generally does, go upon the stand in a fairly judicial frame of mind. The lawyer by his manner of propounding questions or by the exercise of many little persuasive arts incident to his calling, frequently, if not inevitably, leads him into "taking sides." He is surrounded by conditions which, to him, are entirely new, is confronted with verbiage that is strange, even if it be intelligible, and is more or less annoyed and flurried by his surroundings. Under these adverse circumstances he is confronted with the necessity of making a categorical answer to questions that are put to him, more especially in his cross-examination, which cannot be answered categorically. Too few lawyers realize that in a profession like yours—a science or an art like yours, if you prefer—it is often absolutely impossible to answer a question categorically without the risk of conveying to the court or jury, as the case may be, an absolutely erroneous impression. Then, at the close of a more or less lengthy examination, you are often subjected to further imposition in the shape of what lawyers are pleased to term a "hypothetical question."

THE HYPOTHETICAL QUESTION

One of the most glaring evils of medical expert testimony is the hypothetical question which has come to play so important a part in our trials of today. This is the most abominable form of evidence that was ever permitted to choke the mind or throttle the intelligence of a juror. The theory of such questions is that they embrance or express in a few words (sometimes a few thousand) *all* of the main features of the case under consideration—an accurate synopsis, if you please, of all the preceding testimony. They are supposed to be predicated upon *all* of the facts, or assumed facts, bearing upon the question, and no others, and the doctor or surgeon is asked to assume the truth of every fact incorporated in the question, and express to the jury his unqualified opinion and conclusions as an expert from the supposed facts.

In many (probably most) instances, the witness has not seen, much less examined, the patient concerning whose condition he is called upon to give sworn testimony, and the jury often take the answers of the witness as direct evidence of the existence of the fact itself. The hypothetical question itself does not afford as much cause for complaint as does the fact that such questions are too often so loosely framed as to present an aspect of the case entirely different from any which is justified by the testimony. In too many cases an expert who makes a direct and unqualified answer to such questions leaves an absolutely erroneous impression. This explains why so many experts have made answers to such questions which have elicited adverse criticism and affected their professional standing.

It is difficult for a lawyer to overcome the injurious effect of such a question. A method sometimes indulged in is abruptly to demand that the witness repeat in substance the question that he is about to

answer, and his efforts to recall and repeat the various stages of the usually long question which he is about to answer sometimes makes the dangers of such questions immediately apparent to the jurors.

Successfully to combat the effect of a skillfully prepared hypothetical question requires *knowledge, experience,* and *astuteness,* which the average lawyer does not possess. At times it is possible to determine what are those parts of the question upon which the witness places particular stress or to narrow the witness down to some particular factor, the truth of which may have been left in doubt by the previous testimony. It is for the unexpected examination of this kind, as well as for the sentence or *twist* in the question which serves as the foundation for the answer, that the medical expert should be prepared.

Many, perhaps all, of you have been obliged to listen to hypothetical questions so imperfectly constructed that they could not be answered negatively or affirmatively without liability of inculcating errors or necessitating lengthy and qualified explanations, and yet you have seen many such questions answered by "yes" or "no" without the slightest hesitation by one whose conscience is less elastic than is yours.

FALLACIES OF PROGNOSIS

There was a time when the manufacture or exaggeration of injuries in damage cases against corporation had assumed the proportion of a trade among certain lawyers and doctors with distorted ideas of ethics. Fortunately, this practice is now very rare. The fallacy of prognosis is apparent to lawyers and doctors whose duty it is to defend such actions. It is often interesting to watch the history of such a case after a substantial verdict has been awarded and paid over to the suffering and "permanently incapacitated" plaintiff.

You have all heard patients doomed to early dissolution solely on the strength of physical signs, and yet you have seen them live in a most contumacious and scientifically unexplainable manner apparently as long as they desired. The captain of a ship was dying of scurvy, but the crew mutinied and he postponed his dying, put down the mutiny, and is still living. An old lady was near her end after an injury. The doctors agreed that she could not possibly recover, but she became vexed because of a suggested change in her will; made up her mind not to die just then; ordered her carriage and was driven to the home of a relative twenty-five miles in the country, where she lived four years longer. Forty-three years ago it was my misfortune to be seriously injured by the carelessness of a coachman. Had my parents brought suit against the employer of the reckless driver, it would have been an easy matter to find a hundred of the most reputable physicians (had there been so many in Los Angeles at that early date) who would have testified conscientiously that the injured child could not possibly live to attain his majority; that if he did he would be permanently crippled.

With so much fallacy in honest prognostication it is not strange that there is considerable "faking" resorted to by those desiring to pick up some easy money. The honorable member of your profession *must be continually on his guard* to avoid being imposed upon.

SUGGESTED REFORMS

Much of the dissatisfaction with medical expert testimony is due to the shortcomings of attorneys either in failing to understand the requirements of their case or, if they do understand, in being utterly unable to bring out, by well-directed examination, those facts and only those which have a direct bearing upon the particular question under consideration.

Effectively to examine a witness requires that a lawyer should possess at least an outline knowledge of the subject of his examination. It is certain that to construct a question (especially of a hypothetical character) with sufficient skill to elicit a direct and intelligible answer from a medical expert requires more knowledge than the average practitioner of law will take time to acquire. Lawyers possessing the necessary medical knowledge are too apt to want to "show off" before the expert and the jury. My view, therefore, is that, until some way way can be devised of avoiding the present method of eliciting expert testimony, thorough knowledge of medical jurisprudence should constitute a most important part of the required education of every lawyer, and that this branch of study should constitute an important part of the curriculum of every school or college of law, as well as of medicine and surgery. It cannot be doubted that a large part of the confusion and lack of proper methods in introducing and eliciting medical evidence is due to the too general omission of this study as an essential qualification for admission to practice law. In direct line with the suggestion there appeared in the press, a few years since, a dispatch following:

"Medical Courses for Lawyers—An educational innovation has just been put into effect by the Medical College of Loyola University, a Jesuit institution, which offers a course in medicine to law students and attorneys. Recent sensational murder trials have shown the importance, it is alleged, of a knowledge of medicine to the lawyer.

"The course will deal solely with medical and surgical subjects which commonly come up in court trials. Special emphasis will be laid upon the various forms of insanity, but the lectures will also take up anatomy, histology, pathology, neurology, and toxicology.

"The course is offered with the aim in view of preparing attorneys for intelligently questioning medical men on the witness-stand when they are called as experts."

Even in the direct examination of witnesses concerning the nature, extent and probable consequences of personal injuries in both civil and criminal cases, an attorney who has omitted medical jurisprudence from his curriculum of study fails to ask the very questions which would elicit answers of the utmost importance. On the other hand, he frequently wastes much time in pressing questions which are utterly irrelevant or useless. The truth of this observation is borne out by the fact that one of your profession frequently sits beside the attorney in important medico-legal cases, evidently acting as assistant counsel by suggesting the necessary medical questions and references. If the service of the phy-

sician is confined to this it can be countenanced, even though it is not complimentary to the actual attorney. If, as,often happens, he finally takes the stand to give expert testimony in the same case, he inflicts an injury on the character of his profession. The sole duty of a medical witness should be to state such facts and opinions as he believes to be true without fear or partiality, which is difficult, if not impossible, for him to do and at the same time act the part of assistant attorney.

STATUTORY REFORMS

In England and the United States the contesting parties select their own experts and pay them. Equally qualified experts thus appear on both sides and flatly contradict each other.

In France the court may order an investigation and report by experts whenever it deems it advisable. If the parties cannot agree upon at least three experts, the court appoints them.

In Germany, since 1870, after the issues are framed upon which expert testimony is sought, the parties may agree upon the experts, and the court appoints those agreed upon, but it may confine the parties to a given number of experts. Sometimes the court submits to the parties the names of a number of experts, and allows each side to strike off a certain number of them, and then appoints those remaining.

In Prussia it is said to have been the custom to appoint as experts a physician and surgeon for every county. In addition there is a medical college in each province to which an appeal lies if the experts disagree or the parties desire it.

A plan suggested in England and tested at Leeds was for medical men to refuse to testify unless before doing so they could meet in conference with the experts from the other side, and have an interchange of views; and it is stated that the result at Leeds was that medical witnesses were hardly ever cross-examined at all, and it was by no means uncommon to have them called on one side only. The plan is, of course, dependent upon a high standard of moral character and professional honor. The American physician and surgeon, as known to us, is generally qualified to satisfy these requirements.

The American Medical Association some years ago appointed a special committee to consider this question and report some plan. It is my understanding that such committee considered the advisability of having a board of experts of three or more chosen by the respective State Medical Associations, rather than elected by the people in the first instance or appointed by the Governor, who would be available to parties as expert witnesses upon the payment of a fee to the state, as we pay jury and trial fees, and who would act in conjunction with a medico-legal institute, such, for instanee, as the State Laboratory of Hygiene is in chemistry today.

Another desirable method of obtaining reliable expert testimony would be to have the trial judge appoint three well-qualified experts. One might be appointed at the suggestion of each party, and the third at his own direction or by the two thus appointed; and then these three could be required to hear all of the testimony and privately examine such witnesses or parties, and present to the court in writing a report which, as to the facts found, would be binding upon the jury. Remuneration for this service could be divided between the parties to the action, or taxed as costs as are jury fees.

It is only by the adoption of some such course that medical expert testimony can escape the adverse criticism to which it is now subjected.

The adoption in this country and in the various states of some plan such as above outlined, and the enactment thereof into proper laws, would do much to improve the means available to the medical expert of exercising the high prerogative of his science and assist in insuring righteousnss and justice to all.

That a custom has become well established affords no sufficient excuse for its continuance, and if a new custom or method better fitted to present-day needs can be substituted with good results, it is your duty to assist in bringing this to pass.

The study of Medical Jurisprudence should form the most important link between the domain of law and that of medicine; it is the application of the facts and principles established in the more scientific departments of medicine in aid of legal processes for the support and protection of the highest interests of society, the detection of crimes, the preservation of public health, and the more exact administration of justice for all classes of society; it is the common ground upon which the members of the two professions meet for the common purpose of aiding each other in eliciting truth and in applying truth for the protection of the innocent, punishing the guilty, and in preventing or alleviating human suffering under the forms of the law.

The more thoroughly the members of both professions study this branch of human knowledge, the more harmonious will be their intercourse, each with the other, and the more successful will be their efforts to speed up the processes of the law and to promote the administration of substantial remedial justice.

DISCUSSION

Andrew Stewart Lobingier (Merritt Building, Los Angeles)—I listened to the reading of this scholarly address by Judge Burks with singular interest.

Fifteen years ago the Los Angeles Bar Association asked me to address them on this subject at a banquet given by the association to the Supreme Court of California. That was October 15, 1909. During the fifteen years following, under the authorization of the Councils of the Los Angeles County and the California Medical Associations and in collaboration with Mr. Oscar Mueller and Judge Frank Oster of the Los Angeles Bar Association, we have at various times prepared three bills governing expert testimony which were presented to the California legislature for passage. The first bill drafted was rejected by the legislature because it governed the giving of medical expert testimony only, and was considered to be class legislation. At the next meeting of the legislature the bill presented covered the giving of all expert testimony whether medical or from various other professions, as engineers, architects, chemists, etc. This bill passed the Upper House, but failed in the Lower. It was again presented in slightly modified form at the next meeting of the legislature, and was passed by both Houses, but vetoed by Governor Johnson. Not discouraged, Mr. Mueller and myself visited various cities and towns in the state—of course, at our own expense—making addresses before joint meetings of medical and bar associations, or wherever we could get an audience of physicians and lawyers to listen to us, in advocacy of this bill, which authorized the court to appoint its own expert, who by this appointment became an

officer of the court and hence was, as far as could be, divested of bias. The bill provided that counsel for the plaintiff or defendant could still have their own experts whose compensation and appearance they provided for; but the court's expert should examine the plaintiff and testify under direction of the court, though the witness was subject to cross-examination by counsel for either side. The compensation of the court's expert was provided for in the bill. The war came on, and after it one of us was absent from California for several years and nothing more has been done by us toward securing the passage of this legislation. I have learned from Governor Stephens that someone presented a bill governing the giving of expert testimony while he was the executive, and that at the request of several lawyers adverse to it, he had vetoed it, thinking it undesirable.

Whether this was a different bill from the one we have worked so long to have enacted, I am not prepared to say. At the next meeting of the legislature Mr. Mueller and I propose to present our bill again, in the hope it may have favorable consideration by the legislature and the executive. For at least ten or twelve years a number of our Los Angeles Judges of the Superior Court—conspicuously Judge Charles Monroe—have put in practice the calling of the court's expert in cases of doubt and difficulty and with apparently most satisfactory results. We have been privileged to contribute considerable time and assistance in getting the idea of the court's expert popularized in the local courts, and there is a very obvious increase here in the favor in which this method of giving expert evidence is being received.

I have faith that this exceptional address of Judge Burks will stimulate a genuine and widespread interest in this important subject. Since the vast increase in motor car accidents, the number of personal injury cases in our courts would in themselves demand some such assistance to expedite their adjudication.

William C. Woodward, M. D., Executive Secretary Bureau of Legal Medicine and Legislation of the American Medical Association, Chicago, Ill.—The judge, counsel, and an expert must come to an agreement in any case before an expert can get on the witness-stand. For such shortcomings as may appear thereafter, each must bear his part of the blame. For the correction of such defects as now exist in expert testimony generally, judges, lawyers, and the several groups from which expert witnesses are ordinarily drawn should co-operate. But before seeking correction through the enactment of new statutes, it should be definitely determined that existing laws are inadequate, and this seems to be peculiarly the function of bench and bar.

The primary responsibility of the judge is to determine whether expert testimony is needed, and if so, whether each particular witness offered as an expert witness is so qualified. In determining these questions the judge is guided by arguments of counsel, supplemented it may be, in the case of the qualifications of the proposed expert witness, by a preliminary examination in open court. Such examination is limited, however, to an inquiry into technical fitness and does not cover moral suitability. In arriving at his decision, the judge is bound by well-established principles of law. As between judge, counsel, and expert, it may be fairly said, I think, that the judge is the least responsible for such objectionable conditions as are now complained of.

The second collaborator in bringing about the appearance of the expert on the witness-stand is the lawyer. It is on his initiative that expert testimony is admitted. He selects the experts who are to testify for his side and induces the court to permit them to do so. He examines the experts offered by the opposite side, to disqualify them if unfit. He is free to determine whom he will, and whom he will not, present to the court as an expert witness, and in doing so he may take into consideration, not only the technical fitness of the prospective witness, but his moral fitness as well. If he will only refuse to bring into the court witnesses whom he knows, or might easily know, are willing and ready to quibble, to skim along the borders of truth, to evade, to conceal, and even to prevaricate, we shall hear less ridicule of expert witnesses, and expert testimony will be given its normal value. This much the lawyer can do without the enactment of any new law.

The third actor is the expert; but no expert can ever get on the witness-stand unless some lawyer, with the judge's consent, puts him there. So much has been said concerning the expert himself that it is hardly necessary to add anything. That there are occasional experts willing to bear false witness to meet their employer's ends is probably true. Certainly, some witnesses are offered as experts by lawyers, and approved by judges, who could not so qualify among associates in their own professions. And there is a third class made up of men who may have the necessary technical qualifications and necessary integrity, but whose emotional reactions on the witness-stand lead them to unintentional, and it may be unconscious, exaggeration, or concealment. All three of these groups do harm, not only to their professions, but also to the cause of justice. Their conduct attracts public notice and brings condemnation on all, while the vast bulk of honest, competent expert testimony goes unnoticed.

As may be inferred on what has already been said, the problem of ridding the courts of dishonest and incompetent witnesses goes beyond a consideration of the witness himself, and involves counsel, and it may be the judge. The remedy most frequently suggested is, authorizing the appointment by the court of expert witnesses to represent, not the parties, but the court itself. Ordinarily, it is proposed that the testimony of such court experts supplement that of the witnesses testifying on behalf of the parties. A statute undertaking to regulate expert testimony in such manner was passed by the Michigan legislature some time ago, but has already been declared unconstitutional by the Supreme Court of the state (People vs. Dickinson, 164 Mich. 148, 129 N. W. 199). One of the strongest objections raised against it was that the testimony of witnesses acting on behalf of the judge would be given greater weight by the jury than the testimony of the witnesses offered by the parties, and that the parties might be thus deprived of a fair hearing.

But waiving any question as to the constitutionality of such legislation, it may be seriously questioned, I think, whether the situation would be materially improved simply by multiplying the number of experts, and arranging them in three groups, instead of two. If legislation is necessary, and if, in the hope of improving the situation, the court is to be vested by law with additional authority, possibly it should be authorized to appoint a competent expert to act on behalf of the judge, as a friend of the court, to cross-examine in open court the witnesses offered by both sides. The knowledge that an expert witness might be subjected to such cross-examination by an expert in his own line, equally or possibly even more competent than the witness himself, would be likely to go a long way toward deterring incompetent persons from assuming the role of expert witnesses, and would lead even the competent expert to a more thorough preparation of his testimony. Whether it would be practicable to procure men qualified to conduct such examinations, and particularly whether the ethics and clannishness of the particular professional group involved would not hamper such an expert examiner to an extent that might make the entire plan impracticable, are questions that can be answered only by experience.

The Trend Toward Federal Centralization is explained by Walter Thompson, Ph. D., in The Annals Amer. Acad. Pol. and Soc. Science, thus: "Reformers failing to realize their pet reforms through state action are prone to demand federal regulation. It is easier to convince Congress than to persuade forty-eight state legislatures, and the result is more far-reaching. Often reformers fail to realize that the reason state action has not been satisfactory is because the problem is a difficult one to cope with, and to try to realize the reform on a wider scale may increase this difficulty."

The oak tree produces a thousand acorns, from one of which a new tree may grow. We must have a thousand workers in the realm of the arts that one may rise to the plane of greatness. As to why we should foster art—there is but one answer and so obvious a reason that it is hardly worth the stating. Through beauty man's spirit is uplifted; to neglect it is to sink again to the depths from which mankind has risen.—Huger Elliott (The Annals of American Academy of Political and Social Science).

PRESIDENT'S ADDRESS—UTAH STATE MEDICAL SOCIETY, 1924

By J. R. MORRELL, M. D., *Ogden, Utah*

We cannot legislate ourselves into public esteem. We must each one perform a definite individual service, submerging any selfish interest for the common good, and establish a successful co-operative plan of action on the part of the profession in our state if we are to grow in public favor and confidence.

The cure for quackery in medicine lies in our rendering conscientious service with a desire only to do our full duty.

The average man is interested in the health of his farm animals and poultry, but in the family health often only after disease appears.

As long as we attempt to hinder each other in the work of popular health education, just so long will the confidence of the people be withheld from us.

Birth and death reports have been fairly well made, after years of effort, but our hearts are not in the work of vital statistics as they ought to be, and we alone can make a success of this important work.

Expert medical testimony is frequently asked of us and it is a common thing to find a number of men of good standing opposing each other on a case. Many of the most prominent men in our profession have found themselves in this position, and the public has come to regard expert medical testimony as a joke.

We cannot afford to be less efficient than we ought to be. We cannot do less than is expected of us in public service.

THERE are many tempting subjects inviting discussion in a paper of this kind, but I have tried to limit myself to a brief mention of a very few that I feel are of practical interest to our association. Through connection with a few of the official and volunteer health agencies in the state, and through participation in committee work within our organization and in association with outside committees, I have been rather strongly impressed with what I think are real problems that we have yet to solve before we take the place in public confidence that our profession is entitled to hold. These problems concern each individual vitally, and demand that he take a personal interest. The solution cannot be left to the officers of our society, because we cannot legislate ourselves into public esteem. We must each one perform a definite individual service, submerging any selfish interest for the common good, and establish a successful co-operative plan of action on the part of the profession in our state if we are to grow in public favor and confidence.

It is becoming more and more necessary that we have a broader outlook upon our profession than merely to use it as a means of making a living or the accumulation of money. A medical education is a broad, general training that should qualify a man for a much more useful life than he could have by the routine treatment of patients with no higher objective than the average practitioner has. It is a misfortune that a physician should be dependent for his living on fees derived from the treatment of the afflicted, because the temptation to commercialize, which is so strong, often leads one to do things that are not necessary, the results of which may not only be unfortunate, but disastrous. Failure in dealing with the health or life of an individual means much more than failure in commercial lines, and the responsibility is correspondingly greater, and one should not assume it unless he is prepared to justify the trust reposed in him by those who seek his help. A medical education automatically places a man on a pedestal and he becomes something more than a mere man, and if he proves unworthy of that position, not he alone suffers, but the profession of which he is a part is lowered in public esteem and favor because he has failed in his trust. The cure for quackery in medicine lies in our rendering conscientious service with a desire only to do our full duty. We have not only been negligent in our duty to the public, but we have been untrue to each other and have discredited each other in the eyes of the public. Insinuations that lead to suspicion or doubt of the integrity of another are so easy to leave, and praise or commendation is often so difficult that we fail to render a service that would mean much to our cause.

Medical education is expensive and a great part of the expense is borne by the public. Fees collected from students do not pay half the cost of their education, and the balance is paid by the public as taxes or comes from gratuities or endowments of various kinds. Because of the fact that the public has shared in the cost of our education, it is entitled to part of the benefit. We have learned something about preventive medicine, and it is our duty to see that that information reaches the people in order that it may be effective. We can in that way interest people who have confidence in us and at the same time render a co-operative service to the health agencies who are struggling to popularize health education. But we don't often interest ourselves in this work. We have numerous opportunities to instruct, and the majority of people are eager for the information, but we pass up the chance to render a service and they turn to the charlatans and the cults, who are all talkers, trained to teach their theories, and who never lose an opportunity to bring them before the people. We have always had the first chance and our indifference has resulted in a partial withdrawal of public confidence from our entire profession, and this in turn has made the work of health agencies difficult, as people feel that we are attempting to help our own cause and having nothing but a selfish interest in our health activities. If we were united and sincere in our efforts to teach health to the people; if we took the time to impress our patients with our personal interest in them; if we backed up the efforts of public health agencies in their educational work, instead of doing as we often do, ridiculing it, we would establish confidence and might go to any extent in public health education and legislation. The trend toward quackery, and the cults, is because of the sympathetic welcome they extend, with a personal appeal to each one. The large class of working people, whose help and co-operation we need most in public health work, we have to a great extent lost to the sympathetic cults, and our results will always be indifferent until we have re-established their confidence in us by better work on our part. We have scientific truth to offer, with the means of preventing serious illness, and many deaths, and yet because of jealousies, indifference and commercialism abnormally developed, we not only lose the opportunity to render a public service, but create a lack of con-

fidence in our motives. We teach public health in two ways, first, to the child through the school where he is taught health habits. This is the method that will be productive of the best results. But some physicians criticize this work or even antagonize it as a fad, or ridicule it as a useless procedure. The second method is by the teaching of adults, a much more difficult task, as many people are not interested in it. The average man is interested in the health of his farm animals and poultry, but in the family health often only after disease appears. During the recent goiter survey in this state, the only communication to the board of health asking for advice, was from a raiser of hogs who wanted to know how he might administer iodine to stamp out goiter in his herd. We can take a very active part in the education of the adult if we choose to do so, not only by our interest in teaching our patients, lecturing and writing on health subjects, but by giving our support to the work of the health agencies in the state. In the recent goiter survey, examinations of school children were refused by the board of education in one large district, on the advice of local physicians, who ridiculed the work and were able to influence the members of the board against the survey. From various other sources attacks were made on the survey, and doubt engendered in many communities as to the real purpose and intent of the work. As long as we attempt to hinder each other in the work of popular health education, just so long will the confidence of the people be withheld from us. Misunderstandings are often at the bottom of the troubles arising between health agencies, and between health agencies and the general profession. I would like to suggest that our committee on health and public instruction assume the role of intermediary and attempt to bring about co-operative work in all lines of public health activity in this state.

The public is willing and anxious to listen to the medical man whenever he is willing to talk, and he is usually received with enthusiasm by clubs, schools, parent-teachers' organizations and others before whom he might appear. The trouble is in getting him to do it, and while he is coming out of his trance the chiropractor, the traveling "fakir," and the itinerant specialist in diseases of men, women and children, have talked themselves into the confidence of the people and he cannot dislodge them.

The physician is not only the keeper of the health and therein of much of the happiness of his patients, but from an economic point of view he is one of the country's most valuable assets. When we realize this responsibility and organize for good, there is practically nothing that we cannot achieve in the highest interest of our art.

The erroneous belief held by many men that the practices of individual doctors will be interfered with by problems of health betterment which are promoted by lay and semi-medical welfare organizations or by the state, is responsible for much of the opposition of members of our profession. That this is a mistaken position, there can be no doubt, and the greater enlightenment that comes to the public, the better will be their ability to discriminate in their choice of medical help which will ultimately react to our advantage.

We can support and uphold the laws and ordinances of our cities, state and nation, many of which have been enacted after careful study and consideration and have been more or less ineffective because of our indifference. We are expected to report cases of contagion to our local health authorities, to make reports of venereal diseases and of cases of tuberculosis, in order that the communities may be spared needless expense and perhaps many lives be saved. Public health workers checking up our interest in these activities find that we almost entirely ignore the reporting of tuberculosis and venereal cases and whole neighborhoods are exposed and often infected as a result of lack of supervision. Not 50 per cent of the reported deaths from tuberculosis for the last year had ever been called to the attention of the health boards prior to the signing of the death certificate.

Birth and death reports have been fairly well made, after years of effort, but our hearts are not in the work of vital statistics as they ought to be, and we alone can make a success of this important work. Let us not be the factor responsible for failure along this line, but make out our reports of contagious and infectious diseases, especially tuberculosis, as carefully and promptly as we do our reports of industrial accidents, from which we expect to collect a fee.

We have far to go still in the matter of co-operation with each other. As so strikingly told us last year by Doctor Landenberger, we are largely responsible for the troubles we have in the way of damage suits, by our insinuations of poor work or improper practice by another physician. This does not alone hold for personal damage suits, but also for suits against corporations, which are largely dependent for success upon adverse testimony rendered by men of our own profession. Those people with a grievance feel their way around until they find a physician of influence who is sympathetic to their desires, and soon a case is under way. The same attorneys handle most of these cases, and the poor deluded patient is the one who usually suffers, as in the end his compensation is usually less, the doctor is frequently discredited in the eyes of his profession, and the lawyers are the ones who have benefited financially. We should be extremely careful in our testimony in these cases, and professional cooperation and discussion of the merits of the case by the doctors concerned on each side would frequently result in a definite understanding and the testimony of all could be given according to the facts in the case, and we would not see the spectacle now so often enacted, of men violently opposing each other's testimony on the witness-stand and frequently making themselves ridiculous. These cases should be treated as private patients of another doctor, and instead of giving credence at once to any complaint they might have to make against the physician who treated them, make an effort to learn the facts, and talk the matter over with the doctor concerned in an effort to learn the true condition. Usually, if a conscientious effort is made, there is no case developed, and the results are better for all concerned,

as the outcome of a damage suit for personal injury is usually unsatisfactory for those engaging in it.

Expert medical testimony is frequently asked of us, and it is a common thing to find a number of men of good standing opposing each other on a case. Many of the most prominent men in our profession have found themselves in this position, and the public has come to regard expert medical testimony as a joke. They feel that it is just a matter of money and that the desired testimony can always be obtained if the price is right. The remedy for this condition is possible within our ranks if we are willing to co-operate with each other and work only for that which is right. Experts can discuss the merits of a case together, and if they do it with a desire to learn the facts, there is seldom any disagreement. If we do not remedy the condition ourselves, it is only a matter of time until courts will appoint medical experts and withdraw the privilege of employing experts at will.

The University of Utah is giving the first two years of the course in medicine, and is in need of the help of our association to make a success of that work. Last year, President Thomas appealed to us for help, asking that we develop a sympathy for the school and help to popularize it, instead of talking adversely of it. Many of us have not realized that we have a real medical school at the university, with capable men in charge of the departments, and I would advise every member of the association to visit the school and give it a careful inspection. You will find well-equipped laboratories and an abundance of material with which to work, and capable, well-trained men in charge of the work, most of them on full time. The school is a credit to our state, and we should give it our hearty support. Learn exactly what the school is, and then encourage men who are going into medicine to do their first two years' work there. Let us send our boys there as well, as we will then have a personal interest in it and will help to make it what it ought to be. Let us not lose the school to the state. President Thomas is determined to develop a real medical school or to abandon it. Let us co-operate with him and make a school of which we can all be proud.

These suggestions covering a number of fields of activity have appealed to me as our definite problems. We cannot afford to be less efficient than we ought to be. We cannot do less than is expected of us in public service. We owe certain obligations to our profession that we must assume. Lastly, we are indebted to ourselves most of all to play the part in our professional life that will make each one indispensable to our organization.

Eccles Building.

The Year's Record Estimated—Based upon past records and the probable degree of industrial activity, the United States Department of Labor has estimated that the 1924 accident record will show 21,232 deaths, 1728 workmen permanently and totally disabled, 105,629 permanent partial disabilities, and 2,324,829 disabled temporarily, a probable total of 2,543,418 accidents for the year. The actual and potential loss in work-days was estimated as totaling 227,169,970, while the wage loss, using an assumed wage of $4.50 per day, reached the enormous figure of $1,022,264,866.—California Safety News.

RICE WORKERS' DERMATITIS

By HARRY E. ALDERSON, M. D., AND AUBREY G. RAWLINS, A. B.
(From the Skin Clinic, Stanford University Medical School)

During the past few years there have appeared increasing numbers of cases of dermatitis known by those in the industry as "rice poisoning."

The dermatitis should be classed as occupational, whether due to dirt, fertilizers, water, mosquitoes, or other irritants to which men are exposed in their work.

DISCUSSION *by Kendal P. Frost, Los Angeles; Charles E. Schoff, Sacramento; Charles E. von Geldern, Sacramento.*

CALIFORNIA produced 5,469,600 bushels of rice during 1923 from an area of 106,000 acres in Butte, Colusa, Glenn, Sutter, and Yolo Counties, in the Sacramento Valley. Rice-farming, while comparatively new, has developed rapidly until it now constitutes one of the many well-established industries of the State. During the past few years there have appeared increasing numbers of cases of dermatitis known by those in the industry as "rice poisoning." Several cases have come before the State Industrial Accident Commission, and the matter has been referred by them to one of us (Alderson) for investigation. Several cases were studied and it was found that they were produced by lack of proper hygiene at work or at home, and that some of them were cases of seborrheic dermatitis with secondary pyogenic infection. Infected scratch-marks, resulting from bites of mosquitoes which were quite numerous in the rice fields, accounted for some cases. Of course, the dermatitis should be classed as occupational, whether due to dirt, fertilizers, water, mosquitoes, or other irritants to which the men are exposed in their work. Likewise, cases of eczema that develop under these same conditions in workers whose skins are more vulnerable as a result of seborrhea, anatomical defects, or constitutional conditions are certainly to be considered occupational.

A questionnaire was sent to the 130 odd physicians in the rice districts, asking for information regarding cases of rice dermatitis that they had observed. The following are typical of the replies received:

A. has had no cases. B. has had cases which he thinks were due to a dye or an oil in the sacks ("as some have appeared where the men have only handled sacks without being exposed to the rice"). C. has seen many cases. The patients usually had seborrheal skin, and hands, forearms, and legs were involved. D. thinks the disease due to local infection (staphylococcus) which enters through mosquito bites or abrasions in the skin. He states that he has had about three hundred cases. E. has had several cases. F. says that nearly always there are several cases in the rice-mill in his locality. G. (an eye specialist) reports many cases of conjunctivitis among rice workers. H. has seen several cases, but none this year. I. reports that, in his opinion, there is no such thing as a specific rice dermatitis, and that the workers are inclined to call every skin irritation "rice poisoning." He believes that dermatitis often results from handling sacks in the warehouse.

Judging from the replies, it seems that the so-called "rice poisoning" is decreasing in prevalence in

California. This might be due to the fact that there was less rice farming in 1923. The responses to our questionnaire would seem to indicate that a specific rice worker's dermatitis does not exist here, and this opinion for awhile was held by one of us. However, further investigation has convinced us that the reverse is true.

There is very little in the literature on the subject. Mantegazza describes a papulo-pustular dermatitis which involves the feet, legs, hands, and arms of large numbers of the workers in certain rice fields. It affects all ages and conditions more or less alike. Intense itching is a constant feature. The dermatosis subsides soon after removing the patient

1. Barley dust - Low power.

from his work. The author suggests the following possible etiological factors:

1. Predisposing causes: warmth of water, maceration, thinning of skin, alkalies, fertilizer, or other substances dissolved in the water.

2. Determining causes: thorns of a water plant ("najas minor").

3. Complicating causes: ordinary pyogenic organisms.

Sangiorgi describes a persistent itchy erythematous eruption which becomes oedematous papular and then pustular, involving the arms and legs only. He believes that constant immersion in water containing weeds, grasses, and also irritants in solution are the main etiological factors, and does not blame the rice plant itself.

In considering whether or not any given dermatitis is occupational, one should always bear in mind that there are many underlying factors that may increase the vulnerability of the skin. For instance, gastro-intestinal disturbances, indiscretions in diet, alcoholism disturbances of the endocrine gland system, idiosyncrasies for chemicals, food substances, unfavorable home environment, and focal infections. Also there are various local etiological factors, such as anatomical defects of the skin, seborrhea, hyperidosis, diminished secretions of the skin, circulatory disturbances, irritating clothing, overzealous bathing, insufficient bathing, irritating soap, uncleanliness, and hard water.

One of us (Rawlins) had considerable personal experience in this work while a student. From seeing a few cases, working in a rice warehouse, visiting the camps and talking with a large number of the workers, the impression was gained that the dermatitis is produced mainly by the irritating effects of the rice dust. Not a single case was observed (during the investigations carried through the summer) where water appeared to be the cause. All workers (including Rawlins) agreed that the rice dust itself was very irritating and caused severe itching. Barley dust has a similar effect, but the rice dust is more irritating.

In many of the rice workers' camps it was found that sanitary conditions were bad, the bathing facilities being quite deficient. Even where the conditions were good, however, often the workers failed to keep properly clean. It was noted that, even where the men kept very clean, there were numbers of cases of rice dermatitis. An important factor contributing to the general skin irritation is the constant presence of large numbers of mosquitoes in the rice fields. Another observation was that most of the soil in the rice districts is alkaline. This would tend to produce dryness of the skin, thus rendering it more susceptible to the effects of some irritants.

This dermatitis assumes different forms, varying with the individual. It appears to begin usually as

2. = Rice Dust - Low power.

an erythema accompanied by folliculitis with severe itching. Many of the lesions soon become pustular. Numerous excoriations from scratching appear. These often become secondarily infected. The sides of the fingers, flexor aspect of the wrists (thin epidermis), ankles, face, scalp, neck, and upper chest are the regions usually involved. Often there is conjunctivitis, which at times is quite severe. These are the areas, of course, on which most of the rice dust would be deposited. The wrist lesions are usually most aggravated, for here the rubbing of the sleeves or rubbing against the rice sacks are important factors. There are often cases where infected mosquito bites on exposed parts constitute the clinical picture.

For experimental purposes we obtained samples

of rice and rice dust from the various threshers, mills, and warehouses. We have tried to get patients with rice dermatitis for testing with these substances (offering them free hospital beds at Stanford), but so far none have appeared. This is greatly regretted, for such material would have produced valuable evidence, particularly on the subject of specific sensitization to rice. Protein skin tests will be applied as soon as proper material is available. We found one case among the workers who always had dermatitis and asthma when exposed to the grain dust. However, we tried out the materials on our own skins and on several of our clinic patients, utilizing regions where the epidermis was

3. Barley - High power of plant hair.

thin. We used the dry powder, aqueous and alcoholic emulsions of the same. They were rubbed into the skin and then gauze saturated with the material (dry and moist) was applied under adhesive plaster and left on for twenty-four hours. We did not test for protein sensitization. The usual result was a mild, slightly itchy erythema, which subsided in a day or so. It must be remembered, of course, that these conditions were different from those observed in the rice districts. The substance is on the skin of the rice workers constantly for many hours every day. The men, as a rule, are dirty and often irritated by swarms of mosquitoes. Clinical observations made in the rice districts, then, furnish the best, and we believe conclusive evidence that there is a specific "rice workers' dermatitis."

Microscopic examination of the dust shows, largely, a mass of plant hairs. Comparing the microscopic picture of rice dust and barley dust, using uniform preparations in cedar oil, there are about five times as many of these barbs in the rice as in the barley dust. (Note drawings.) This fact might help to explain why the rice dust is more irritating than the dust from other grains in the same vicinity.

Regarding the composition of rice, it was found that, unlike other grains, it contains a high percentage of silicon (about 16 per cent). This may account for the dust particles being more needle-like, and consequently irritating.

As far as we can learn, the najas minor plant (mentioned in Mantegazza's article) is not found in California. From the foregoing observations we feel justified in concluding that:

1. There is a specific rice workers' dermatitis, due to the peculiarly irritating qualities of the rice grain. It has not yet been determined if protein sensitization is a factor in some cases.

2. There are also occupational dermatoses appearing on the skin of rice workers, as a result of scratched, infected mosquito bites, and dirt or both.

3. Unhygienic conditions in some of the camps and homes of the workers, as well as lack of personal cleanliness, account for some cases.

240 Stockton Street, San Francisco.

DISCUSSION

DR. KENDAL P. FROST (831 Pacific Mutual Building, Los Angeles)—Dr. Alderson's paper is a very stimulating one. There being no cultivation of rice in my section of the state, I have not had an opportunity to observe any of these cases. From the description I should be inclined to feel that the condition is not due to rice protein sensitivity, but rather to the mechanical irritation plus infection. Of course, there may be cases of rice sensitivity. In these one would anticipate a more eczematous syndrome.

CHARLES E. SCHOFF, M. D. (Farmers and Mechanics Bank Building, Sacramento)—I am pleased to have the opportunity of saying a few words relative to Dr. Alderson's paper, and it shows that he and Rawlins have spent considerable time upon this subject, which at one time was a much debated point, particularly with the State Industrial Accident Commission.

My experience with rice worker's dermatitis has been limited to five cases, three of which were definite dermatitis and two which proved, on investigation, to be a trichophyton in sack handlers of rice.

The cases were all referred to me after having been in progress some length of time, and were in individuals who were employed in the handling of "paddy rice" in the warehouse.

The skin manifestations varied from lesions confined to the hands, lower forearms and lower legs to a gen-

4. Rice - High power of plant hair

eralized involvement. There was nothing particularly peculiar to this type of skin irritation in its specific self, it being a papular, vesicular, traumatically excoriated, secondarily infected, diffuse, oedematous type of dermatitis, appearing first on the exposed surfaces and being confined there or spreading mechanically to the covered parts of the body.

The hygienic conditions surrounding these cases were good, two of them being men of families and homes, and the other housed in a hotel with facilities for body cleanliness and bed changes. Nor did I think that any of the cases presented a seborrheic type of a skin.

I merely mention these two facts to bring out the point that these cases developed in an atmosphere peculiar to

themselves; they persisted in that atmosphere and cleared up in due course of time when removed from the producing environment. It is of interest to note that one of the cases returned to work in the mill, and in a short time had a slight recurrence which necessitated his giving up that type of work, as he had been advised.

Another point of interest is that these cases do not develop in any other department of the mill other than in those who are handling paddy rice. I am informed from the mill management that clean rice workers, i. e., those employed in the polishing department, are free from such discomforts.

The trichophyton cases were peculiar, in that their lesion appeared practically at the same site although on opposite forearms about two inches above the flexure fold of the wrist, in truckmen who were handling rice—one employed in the field and the other in the warehouse.

The lesions were annular, about one and one-half inches in diameter, papular pustular, discrete folliculitis, the hairs showing a small spored ecto-thrix in both cases, with very few mycelium present.

Some work was attempted without results in an effort to determine if the animal habitue (cats and rodents) of the warehouse might have been the source, or if the mould on the sacks might have been responsible.

I quite agree with Dr. Alderson that there is a definite dermatitis produced in workers in rice. Whether this is due to a mechanical irritation from the dust, a chemical irritation or a protein sensitization still leaves a field for further investigation.

I question the protein sensitization, on the ground that if it were so it seems to me that we would see some of the cases originate in the polishing department of the rice mills, where the clean grain is handled entirely.

CHARLES E. VON GELDERN, M. D. (Forum Building, Sacramento, Calif.)—That the so-called rice workers' dermatitis is comparatively rare is shown by the scarcity of the literature and the fact that so few of these cases come under the care of industrial surgeons.

I fully agree with Dr. Alderson and Rawlins that the so-called rice workers' dermatitis is due to the irritating qualities of the rice grain which appear in the dust during the harvesting and in the milling. I saw, a number of years ago, a patient who had caulked a leaking feeder in one of the mills, and was subjected to dust and rice-hulls for a number of hours. His face, especially on the left side, was red, swollen and tender, with numerous small discrete papules. The itching was intense. The forearms were not affected to quite the same extent. The parts covered by clothing were not involved, which showed that the effect was a direct one.

A comparatively large number of rice workers have been sent to me for treatment for dermatoses. In most of these, the history did not show any relationship between their occupation and the disease. The most common affection was impetigo contagiosa. Two workers came from the same mill, at the same time, with a trychophyton infection. One of these men was employed in cutting out mouldy portions in sacks of rice which had been subjected to moisture. The other employe worked in the mill and did not come in contact with the first one, yet the lesions were similar in nature and location. At the time I made an investigation of the mill, but was unable to establish any definite relationship between the disease and the occupation. The manager of the mills had heard rumors regarding the cats which were said to be infected, but on investigation no disease was found among them.

On investigation, the various rumors and lay opinions were not substantiated, and at best the belief that the rice dust was the causative factor was merely suggestive.

It is, however, fairly certain, as shown by Alderson and Rawlins, that rice dust does produce a dermatitis in certain susceptible individuals, due to its abrasive action. It has not been shown, however, that such a dermatitis is specific, for, unless a clear history is obtained and the cases observed at an early stage, it is not possible to assert with any degree of certainty the cause of the skin manifestations.

Many of the dermatoses should be classed as industrial diseases, unless it can be definitely proved that the factors producing them are not connected with the occupation. This is manifestly difficult, but it is only fair to the worker that he be given the benefit of the doubt.

DOCTOR ALDERSON (closing)—I wish to thank those discussing our paper for their valuable suggestions.

All available evidence is against there being specific sensitization to rice in these cases. Observers agree that the dermatitis is due rather to factors producing trauma or infection or both. As noted by Schoff and Von Geldern (who practice in the rice territory) cases are seen only among those exposed to rice before it is cleaned. If specific sensitization were a factor, cases would appear among those handling only the polished rice. Furthermore, as observed by Frost, the eruption would be more eczematous in character.

What One Health "Officer" Thinks of Baby Shows—"These baby shows make me sick. Think of hauling around a number of babies in the heat, dust and dirt that obtains at the usual county fair. Supposedly, this is done for the benefit of the babies. Actually, it is done because someone is making some money out of it, and so far as the poor babies are concerned it amounts to nothing. A fellow came in a few months ago. He said he was going to put on a baby show for one of the papers. I bluntly asked him where he would get his compensation, and he said he was an expert baby photographer. I told him, so far as the health department was concerned, there would be no sanction of his campaign, and so far as I was concerned, personally I was opposed to any such commercializing of child welfare. This fellow proved an expert liar. He went around and told other doctors and the visiting nurses I was in perfect agreement with his plans and he had everything set. I heard of this. I saw the editor of the paper and had a friendly talk with him, and gave him some ideas about baby contests he did not have. When the fellow returned to put on his campaign he found there was not a doctor in our city who would have anything to do with him. Of course, the nurses were ready, but the editor of the paper refused to go on with the thing, because he had become convinced that it was not really a child welfare proposition at all. So, we headed this one off. But later the —— got mixed up with a combined beauty, better-baby-popularity contest. Those of us who are interested in pediatrics refused to have anything to do with it, but some of the other men spent some time at the county fair looking over the babies. What possible good can come to the babies in such hastily conducted examinations? I am off these things for life."—Indiana Medical Journal.

Wagner-Jauregg Treatment of Paresis—Doctor Jossmann, in reporting 100 patients treated by this method (Medical Standard), says that all stages of paralysis were treated by the method, and the result was that twenty-one patients were enabled to begin working again, although slight traces of paralysis were still present. Twenty-eight patients were able to resume work to a limited extent, the paralytic symptoms having undergone a considerable amelioration. In thirty-nine patients no improvement worth mentioning was noticeable, and twelve patients died during or in consequence of the treatment. Even in the improved cases slight disturbances of speech and irregularity of the pupils remained. The intellect did not entirely return to normal, and a lack of insight into the state of illness remained. Jossmann comes to the conclusion that, although it is still too soon for a final judgment to be passed, it has nevertheless been ascertained that, during the eighteen months in which the Wagner-Jauregg method has been available, improvement has taken place in about 50 per cent of the patients, especially in the early stages of the disease.

"For of Such"—The three realms of Fairyland, of Art, and of Nature constitute our being. The re-entry to fairyland, that land of wonder in which we never grow up out of that heaven which lies about us in our infancy, can be won by cultivating the friendship of children and by the study of the beauty of life in the land of dreams, out of which we may achieve when awake the realization of life's duty.—British Medical Journal.

CORONARY OCCLUSION AND MYOCARDIAL DEGENERATIONS

SOME CLINICAL AND PATHOLOGICAL CONSIDERATIONS

By WM. J. KERR, M. D., AND S. V. LARKEY, A. B., A. E. LARSEN, A. B.

(From the Department of Medicine, University of California Medical School, San Francisco)

Disease should be more frequently recognized than it is.

Any male individual past 50 years of age (all fifteen of our patients were males) who, with or without previous history of cardiac symptoms presents a history of severe, agonizing, persisting pain in the chest or upper abdomen, accompanied by dyspnoea, unrelieved by rest, should be considered a probable sufferer from coronary disease.

Brief monographic consideration of all features of the disease.

CAREFULLY CONSIDERED DISCUSSION *by James F. Churchil, San Diego; F. F. Gundrum, Sacramento; Thomas H. Kelly, San Francisco.*

THERE is a striking increase in the number of deaths from the so-called degenerative diseases, due probably to the fact that more people are living into the age when these maladies tend to occur. With this increase, more emphasis is being placed on the early recognition and treatment of disorders of the cardiovascular system, associated with degenerative changes in the arteries. Coronary artery disease, with the resulting myocardial degeneration, is, therefore, of special interest. It is more common than earlier writers would have us believe.

The diagnosis of coronary occlusion, by thrombus, can be made in a considerable number of cases during life and suspected in a large number of cases where sudden death has occurred in individuals past 50 years of age. The condition should be more generally understood because, in its symptomatology, confusion with acute processes in the chest or abdomen may result. Needless and harmful abdominal operations are sometimes performed on patients with abdominal symptoms when the provocative disease process is in the heart or pericardium. A sufficiently large number of patients survive the first attacks of coronary artery occlusion to demand its recognition so that treatment may be adequate to promote the establishment of collateral circulation or the fibrosis of an infarcted area.

Our knowledge of the subject dates from the time of William Harvey, who described the symptoms and necropsy findings in a case where a large rupture of the left ventricle occurred. From then until the latter part of the nineteenth century a few case reports appeared in the literature, and many of the important points in regard to the condition were emphasized. In a monograph Robin and Nicolle, in 1895, gave an excellent review of rupture of the heart. More recently Dock, Huchard, Osler, Herrick and his co-workers, Gorham, and particularly Wearn, have clarified the clinical and pathological picture. Levine and Tranter reported two cases of infarction of the heart stimulating acute surgical abdominal conditions with necropsy findings. Crohn presented six cases of coronary disease where the abdominal symptoms and findings masked the true condition.

In two of these cases a previous history of peptic ulcer had been made. The electrocardiographic study of three patients with coronary artery disease with infarction by Kahn suggested the possibility of diagnosis by variations in the ventricular complex during the progress of the case. Reznikoff described a case with rupture of the left ventricular wall where stethoscopic evidence was obtained when the rupture took place. The sound was described as a "muffled, low-pitched, rushing rumble, louder in the expiratory phase."

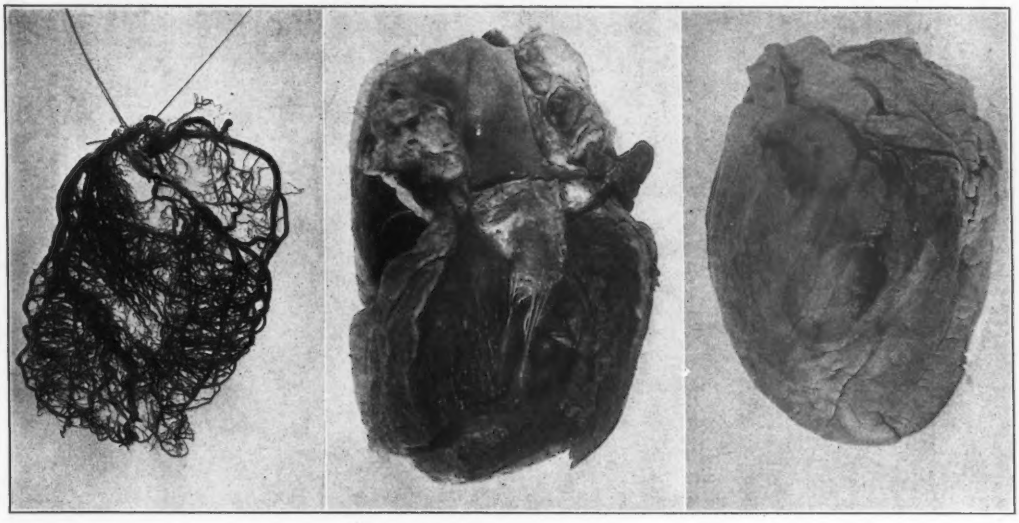
Oberhelman, using a mercury injection method, showed a variation in the size, position and anastomosis of the coronary arteries in normal hearts and suggested that the time element was important in cases where occlusion occurred. This study confirmed the previous work of Herrick and Gross. Our studies with celloidin injection and corrosion preparations and bismuth sulphate injection preparations, which will be reported later, are in accord with previous observations on the coronary circulation.

Our study is based on fifteen cases observed during the past three years where both clinical and pathological data are available. An equal number of cases where the clinical histories were inadequate, or where necropsy findings were not obtained, are not included in this report. In a study of the data (Chart I) certain deductions may be drawn which, in the main, agree with previous work and are of importance in dealing with the condition.

ETIOLOGY

No outstanding etiological factors were noted. Eleven of the fifteen cases were in individuals after the fourth decade. Of those under 40 years of age, two showed subacute bacterial endocarditis which probably was responsible for infarction by embolism. In two patients, only 32 and 38 years of age, respectively, no etiological factors could be ascertained. Both individuals showed very extensive generalized arteriosclerosis. There was wide variation in occupation which is in agreement with the observations of Wearn. The preponderance of coronary disease among the male sex is shown by our series, all fifteen being observed in men. Heredity did not seem to play a role in our cases. In only one case was there a definite family history of heart disease. Infectious diseases were rarely observed in the previous histories. In four cases there was a history of rheumatism. Two of these showed subacute bacterial endocarditis with probable embolism to the coronary arteries with myocardial changes. In the other two no evidence of valvular heart disease was found at necropsy, although in one case pericardial adhesions were observed.

A history of lues, twenty-nine years before death, was obtained in one case and a positive blood Wassermann was recorded. Necropsy showed fibrosis of the interventricular septum and aneurysm of the left ventricular wall. In another case a weakly positive Wassermann was obtained, and necropsy showed a luetic aortitis in addition to a chronic fibrosis of the myocardium and mural thrombosis of the apices of both ventricles. Lues is not, therefore, a constant etiological factor, if our present methods



NO. 1

Injection-corrosion preparation of the coronary circulation of a human heart with coronary sclerosis.

NO. 2

Left ventricle of a human heart, showing extensive infarction with mural thrombi and an older process at the apex with thinning of the apical wall.

NO. 3

Human heart with occlusion of the left coronary and extensive infarction. Necrosis of the wall of the left ventricle is shown with a large irregular rupture of the myocardium. Sudden death after severe precordial pain and dyspnoea for four hours.

of clinical and pathological study are adequate to reveal end stages of this disease.

SYMPTOMATOLOGY

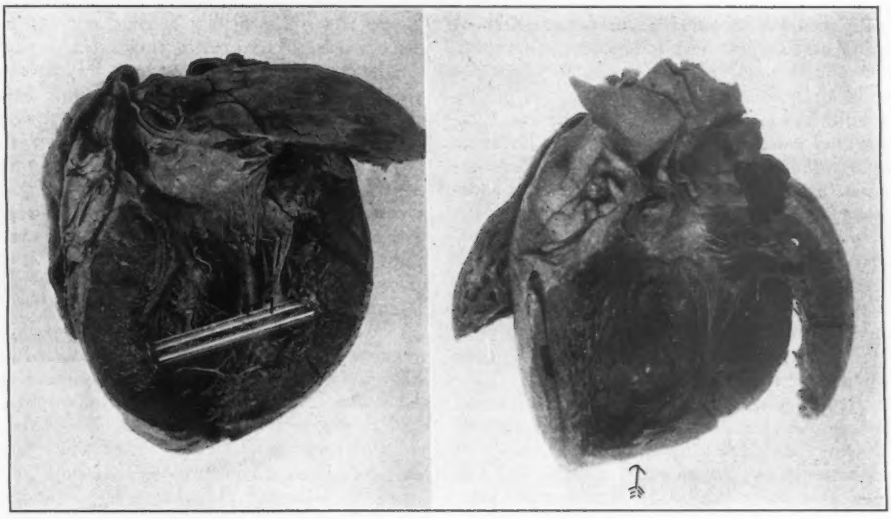
While there is considerable variation in the clinical picture of coronary disease, most of the features become intelligible when we consider the pathological changes in the heart and pericardium. We omit from our discussion the controversial points in regard to the causation of the attacks of pain in angina pectoris. In general the changes in the myocardium, in coronary disease, vary with the site and degree of the occlusion by atheroma, thrombosis, embolism, gummata or tumors; with the size of the occluded vessel; with the extent of the anastomosis in the area affected, which may vary normally and with advancing age of the individual; and with the time element in the process of occlusion. Small areas of the myocardium may become infarcted without any history or symptoms to indicate when the lesions were produced. Subjects with such lesions may show nothing on physical examination but enlargement of the heart. Occlusion of the descending branch of the left coronary artery, which is the most common lesion described, may lead to sudden death if the interruption of the circulation is abrupt, whereas if the obstruction is gradual, the infarcted area is usually smaller and the subject may survive. The process in the heart muscle may become necrotic with rupture of the wall, or organization may take place with resulting fibrosis or aneurysm of the left ventricular wall at or near the apex. Lesions of the septal branch, when acute or chronic, commonly result in serious disturbances of the conduction system. Occlusion above the septal branch lead to widespread pathology in the heart with a high immediate mortality. Other branches of the left coronary artery are less commonly involved, but may be affected above or in association with those previously mentioned and produce less obvious symptomatology. The right coronary artery is occluded less often than the left except in luetic involvement of the base of the aorta, where there apparently is a preponderance of infarction of the right ventricular wall. Infarctions of the heart, if extensive enough to involve the endocardium, frequently lead to mural thrombi which, by embolism to the greater or lesser circulation, complicate the clinical picture accordingly. Similarly, processes in the myocardium, extending to the epicardium, frequently present the symptomatology of pericardial disease.

SUBJECTIVE SYMPTOMS

Pain is probably the most constant symptom which is met with in coronary disease. If it occurs after a history of angina pectoris the pain is described by the patient as entirely different in nature from that previously noted. It may occur without previous symptoms suggesting cardiac trouble. Its persistence and agonizing character are striking features and may be unrelieved by rest and large doses of morphine. The location of the pain varies widely, but is most commonly described as under the lower sternum or in the epigastrium. The pain may be referred to the left side of the neck, down the left arm, to the left sub-scapular region or to the upper part of the abdomen. In some cases there is a widespread distribution of the pain. Sensory disturbances of the skin may be noted over the precordium or over the painful areas. Dyspnoea persisting, in spite of rest, is a fairly constant feature. Gastro-intestinal symptoms, including upper abdominal pain, nausea, vomiting, pyrosis and flatulence, frequently direct the attention of the patient and physician to the abdomen. Mistaken diagnoses of perforated ulcer, gall-bladder disease, acute pancreatitis, and other

CHART I

Hosp. No.	Sex	Aet.	Etiological Factors	Dyspnea	Symptoms, Pain	Oedema	Cyanosis	Enlarged Heart	Signs: Heart Sounds	Signs: Murmurs	Leukocytosis	Peripheral Vessels	B. P.	Coronary Sclerosis & Myocardial Change & Myomalacia
A-21-188	M	38	None	0	Region Xiphoid 4 years.	0	0	0	0	0	0	0	140/80	Marked coronary sclerosis & obliteration of lumen; extensive myocardial degeneration.
#21	M	58	Family history +. All members died of heart trouble.	—	Precordial pain 1 week.	—	—	—	Faint	Late, rough systolic.	—	—		Marked coronary sclerosis & thrombosis and myomalacia resulting in rupture of left ventricle.
A-21-123	M	50	Bad tonsils	+ 3 wks.	Severe pain over heart and down left arm.	—	—	+	Distant	None			175/125	Stenosis left coronary & thrombosis. Extensive myomalacia left ventricle & mural thrombi and pericarditis.
A-22-54	M	55	Father, heart trouble. Hard worker.	+ 5 yrs.	Pain under the right rib margin over heart, down left arm for 1½ years.			++	Faint	Systolic apex.	19,600	Slightly thickened.	100/84	Coronary sclerosis & occlusion marked fibrosis left vent. and interventricular septum & mural thrombi. Apex completely fibrosed & pocketing infarcts. lungs — C. P. C. terminal septicemia.
#A-22-85	M	58	Negative	+	Precordial and arms on exertion, 1 month.	+	—	+	Distant	Systolic apex faint.		Slight thickening.	118/52	Mural thrombosis left ventricle & degeneration of anterior wall. Atheroma aorta-aortic, mitral, valves.
A-22-10	M	67	Syphilis	0	Severe pain epigastrium.	—	—	+	Distant	Soft apical systolic murmur.		Tortuous hard.	108/65	Ca. of stomach & liver metastasis. Fibrosis interventricular septum. Aneurysm left ventricle, syphilis.
A-23-78	M	63	None	++	(Was in coma)	—	—	++	Distant		20,000	Slightly thickened.	140/78	Infarct. brain general arteriosclerosis, coronary sclerosis, infarct. myocardium.
A-23-82	M	58	Heavy drinker	++ 7 yrs.	Attacks 7 years. Epigastric precord. radiating down left arm.	—	+	+	Distant	Loud systolic apex.	14,500	Gangrene leg.	118/70	Coronary sclerosis; infarct. left ventricle, myomalacia & aneurysmal dilatation left ventricle; fibrosis myocardium; pericardial adhesions multiple throughout body.
A-23-166	M	67	None	+ 4 yrs.	Precordial left forearm runs up chest; 4 years.	—	+	+		Systolic apex.	25,000		110/80	Arteriosclerosis, myomalacia left vent. mural thrombi, fibrinous adhesions pericardium.
A-24-16	M	32	None	+++	Epigastric lower chest 1 day.	—	++	+			14,000		90/78	Marked coronary sclerosis & diffuse fibrosis both ventricles. Hemorrhage in brain & mural thrombi.
A-22-93	M	68	Scarlet fever, rheumatism, malaria.	+ 6 yrs.	Attacks 2 years. Precord. to left arm and shoulder.	8 yrs. +	—	++ +	Faint	Harsh systolic apex.	9,200	Tortuous hard.	132/52	Narrow coronaries; fibrosis heart; pericardial adhesions; carcinoma rectum.
A-22-73	M	71	Rheumatism, influenza.	+ 3 yrs.		+	—	+	Faint	Aortic systolic. Mitral systolic.			130/90	Extensive acute thrombosis left ventricle and right ventricle. Fibrosis intervent. septum.
A-22-198	M	25	Three attacks rheumatism.	+ 1 yr.	Precordial	Late	+	+	Good quality.	Rough syst. & thrill.	6,000		120/70	Subacute bacterial endocarditis. Acute and subacute myocarditis; thinning fibrosis myocard. left ventricle. Infarct. spleen C. P. C.
A-23-165	M	35	Rheumatism, influenza.	Late				+	Accentuated.	All valves	14,000	Water hammer.	138/0	Subacute verrucose endocarditic mitral, aortic, pulmonic occlusion left coronary.
A-20-1	M	57		+ 4 yrs.		Late	++	++	Gallop rhythm.			Thickened.	180/120	Marked cardiac hypert. & dilatation mod. fibrous myocarditis. Thrombosis apices both ventricles luetic aortitis.



NO. 4
Same as Fig. 3. Left ventricle opened to show the rupture of the wall adjacent to the septum. Extent of rupture from x to y.

NO. 5
Human heart, showing old area of infarction at the apex of the left ventricle with resulting fibrosis and aneurysmal dilatation.

diagnoses may result in needless and dangerous surgical procedures. (One of our patients was operated on for a suspected gall-bladder disease, and at necropsy was found to have coronary occlusion, with extensive infarction of the heart.) Vertigo and syncope associated with a failing myocardium or cardiac irregularities may be presenting symptoms. Emboli, lodging in the peripheral or pulmonary vessels, may be the first indication of coronary disease. Any or all of the above symptoms may be noted. However, many patients die suddenly without previous symptoms, and as such constitute a large percentage of sudden deaths. A small number of patients may give no history of cardiac disease, and at necropsy show fibrosis or aneurysm of the heart wall, indicating an old healed area of a previous infarction.

OBJECTIVE SYMPTOMS

There is a wide variation in the objective findings of patients suffering from coronary disease. In the more severe types the appearance of extreme suffering, prostration, ashen-gray appearance, feeble pulse, weak heart action, increased respiratory rate, passive congestion of the lungs, slight fever and leucocytosis make up the picture. The frequent accompaniment of tenderness and rigidity of the upper abdomen and distention complicate the picture and often mask the true nature of the disorder above the diaphragm. The enlargement of the liver, commonly of the left lobe, may simulate an abdominal mass or tumor of another nature. Libman describes sudden enlargement of the liver and cyanosis in association with right coronary occlusion. The roentgen ray findings in the stomach may give a constant but false picture of neoplasm or chronic ulcer such as occurred in one of our cases. Cardiac murmurs are common, but not characteristic. Previous rheumatic affections of the valves and luetic or sclerotic processes may present complicating diagnostic features. Subacute bacterial endocarditis may be the underlying process leading to embolism and infarction. Pericardial rubs are occasionally observed, and if noted are usually indicative of rather extensive infarction. Patients who survive one or more attacks of coronary occlusion may present the signs of congestive heart failure which often obscure the true nature of the underlying pathology. Cardiac irregularities, varying from extrasystoles, partial to complete heart block and ventricular trachycardia, are observed. Auricular fibrillation, auricular flutter are less often observed except with a failing myocardium. Electrocardiographic tracings show wide variations in the degree of block, shape of the Q-R-S complex and the T wave deviations, depending on the location of the lesion and its extent. Changes in the curves are noted with the varying clinical course. The blood pressure varies, but is usually lower than the readings for the respective age periods.

DIAGNOSIS

The diagnosis is made on a consideration of the above symptomatology. Few mistakes would be made if we keep in mind the possibility of coronary artery disease and myocardial degenerations in patients past 50 years of age who present upper abdominal symptoms.

CLINICAL COURSE

Sudden death is commonly observed. The usual duration is a few hours to a few days. Recurrent attacks may be noted over a period of weeks to years. Patients may rarely survive one or more attacks with fair or apparently normal cardiac function. Usually, however, the reserve force of the heart muscle is seriously impaired. Such patients must, therefore, lead a restricted physical and mental life. The outlook is gloomy, with the ever-present danger of subsequent extension of the process with sudden death. The prognosis should be guarded.

TREATMENT

The treatment is of greatest importance in the

group of patients who survive the first attack. A long period of complete rest is absolutely essential, free from physical and mental strain, to allow for fibrosis and anastomosis. Signs of myocardial insufficiency should be properly treated by depletion, limitation of fluids, diet with frequent, small feedings of easily digested, non-gas-producing food. Paracenteses may be necessary to remove embarrassing accumulations of fluid. Digitalis should be pushed to full effects during the stage of congestive heart failure, and small doses should be continued for a long time thereafter. A combination of digitalis, squill, and calomel is useful. Nitrites may be of value in controlling anginal pain, but morphine is usually required for the more persistent pain. Even large doses of morphine may fail to relieve the pain. Pyrosis and flatulence may be reduced by diet, free, regular, daily bowel movements, soda, prevention of air-swallowing, and other measures. This may be the most troublesome symptom to control and tax the ingenuity of the physician. Those patients who have outstanding abdominal complaints are difficult to convince that the diseased organ is the heart.

The acute fulminating cases present some different problems in therapy. Usually there is the picture simulating surgical shock. Rest is voluntarily accepted by the patient. There may, however, be great unrest and moving about in bed because of the severe pain. If nitrites give no relief—and usually they do not—opiates are indicated. Morphine may be given in increasing doses, and in many cases will promote rest and sleep. Caffein should be given in two to five grain doses intravenously or in larger doses subcutaneously. Distention should be relieved by stupes, gas enemata, a soft catheter in the rectum, and aromatic spirits of ammonia by mouth. Acute pulmonary edema, if present, should be treated by morphine and atropine. Venesection should be done if there is marked cyanosis, with enlargement of the liver, and the blood pressure is not too low.

PATHOLOGY

Almost without exception there is enlargement of the heart, the weight averaging from 400 to 500 grams. Atheroma of the coronary tree is a constant finding as an underlying factor responsible for changes in the myocardium. Occlusion takes place by gradual narrowing of the lumen at one or more places. Thrombus generally is found at the site of atheromatous processes and usually has caused a more sudden obstruction. However, calcareous plaques may be carried from the base of the aorta or portions of mural or valve thrombi may be dislodged from the left heart and lodge in the vessels, stopping the circulation to a portion of the ventricles. Gummata and tumors may rarely be the causative agents in restricting the coronary circulation. The resulting changes in the myocardium go through the various stages, leading eventually, if the patient lives, to fibrosis. At first there is local ischemia, which is smaller in area than the past supplied by the involved coronary, depending on the degree of anastomis. Microscopic sections show an accumulation of fibrin and leucocytes and extravasation of erythrocytes. In some instances small miliary abscesses are noted and the infarcted area is soft and friable. These features probably account for the fever and leucocytosis so frequently found. The presence of the leucocytes in such numbers indicates an older process than the duration of symptoms would indicate in many cases. The muscle fibers appear pale and swollen and the nuclei are piknotic. Fragmentation and further degeneration of muscle fibers may occur. As the process continues, granulation tissue forms, and the dead tissue is gradually replaced by firm fibrous tissue. A few muscle fibers may remain scattered through the scar tissue, but if the area involved is large the degenerated muscle tissue may be entirely replaced. The adherence of the parietal pericardium over the affected area may support the weakened ventricular wall or the diseased area may bulge outward, producing an aneurysm. Rupture of the ventricular wall with hemorrhage into the pericardial sac and death may take place during the stage of necrosis, but rarely later when fibrosis has occurred. Reinvolvements in adjacent or remote coronary branches reduplicate the original pathological picture.

Involvement of the pericardium accounts for the pericardial rub and pain in some cases. The severe constant pain over a wide distribution is not as yet fully explained, but much of the symptomatology can be interpreted as referred pain and spasm. The embolic phenomena are readily understood. The occurrence of irregularities and heart-block can be correlated with the pathological findings in many cases. The pathological findings, aside from those in the heart, are in general those of arterial degenerative disease in various organs, such as brain, kidneys and intestines, and the group of changes classified under the head of myocardial insufficiency.

SUMMARY

In a group of fifteen cases of coronary disease the clinical and pathological features have been studied. Our findings bear out the contentions of previous authors that coronary disease should be more generally recognized than it is. The symptomatology is confusing unless the underlying pathology is understood. Any male individual past 50 years of age (all fifteen of our patients were males) who with or without previous history of cardiac symptoms presents a history of severe, agonizing, persisting pain in the chest or upper abdomen, accompanied by dyspnoea, unrelieved by rest, should be considered a probable sufferer from coronary disease. The surgeon should be particularly on his guard in such patients with upper abdominal symptoms and signs. Extreme pallor and prostration, feeble pulse and heart action, low blood pressure, enlargement of the heart, passive congestion at the bases of the lungs, enlargement of the liver, slight fever and leucocytosis confirm the diagnosis. Such findings of murmurs, irregularities, embolic phenomena may help to locate the site of the process in the heart. The roentgen-ray examination may show a heart of unusual size or shape.

The course is variable, depending on many factors: namely, the causative agent, site of lesion, richness of anastomosis, and the time during which the occlusion takes place. The prognosis is poor and

death is frequently sudden. The treatment depends on the stage of the process.

University of California Hospital, San Francisco.

DISCUSSION

JAMES F. CHURCHILL, M. D. (Electric Building, San Diego, Calif.)—The group of cases in which there is an occlusion of a small branch of a coronary vessel and in which the patient frequently survives the attack is the one of chief clinical interest and importance. These cases are probably far more common than is suspected. Clinicians are making an increasing number of presumptive diagnoses of coronary occlusion to the great benefit of many of these patients. A careful pathological study of clinical material as presented in this paper is of great value to internists and general practitioners alike.

In this relatively mild group of cases the chief difficulty in differentiation is between obstruction and angina. In this differentiation I have come to rely chiefly on two points: first, the pain of angina is ordinarily relieved, at least temporarily, by vasodilators, while that of coronary occlusion is not; second, in coronary occlusion there is usually an immediate and marked fall in blood pressure, while in angina it is usually unchanged. It is true that there is often noted a fall in blood pressure some hours after repeated and severe anginal attacks, but it is not so abrupt nor so marked as in the other case. Therefore, it has become my habit, on seeing a patient with severe pain of anginal type, who obtains no relief from vasodilators and who shows a distinct drop in blood pressure, to make a presumptive diagnosis of coronary obstruction and to treat him accordingly. I believe the patient's chances of surviving the attack are increased by this policy.

The other cases for which we should ever be on the alert are those simulating upper abdominal lesions. The essayist has brought out this point and I only wish to emphasize it.

It is my observation that the majority of general practitioners are quite unfamiliar with coronary occlusion and, therefore, do not have in mind the possibility of that lesion in differential diagnosis. For that reason I would urge the presentation of papers on the subject before the County Societies.

F. F. GUNDRUM, M. D. (Capital National Bank Building, Sacramento, Calif.)—I find this excellent paper very timely. Our text-books say relatively little about coronary occlusion, and I believe most of us have usually considered it merely as a pathologic curiosity in some of the cases of sudden death. The clinical picture of sudden occlusion of a large coronary branch; the ashen-gray pallor; blue-purple lips; extreme prostration, sweating; weakness of voice and almost unbearable pain would be difficult to forget or confuse with any other condition. The picture, however, is not always so extreme. Whenever any patient, particularly if he be middle-aged, suddenly experiences a severe pain, cardiac, upper abdominal or brachial, after slight infection, overexercise or a large meal, and this pain is accompanied by great physical weakness, aggravated by exercise and unrelieved by vasodilator drug, such as whisky, nitroglycerin or amyl nitrite, coronary occlusion must be thought of as one of the first probabilities. It is of first consequence to the patient that this contingency be not overlooked. For any unnecessary manipulation, such as laparotomy or even passage of stomach tube for gastric juice examination or duodenal tube for investigation of the gallbladder by the so-called Lyon technique, with its attendant retching, may be productive of a fatal mischief. Diagnosis is difficult, and physical signs much less helpful than careful history. These patients do not always die immediately after a blood vessel has been plugged, but occasionally live on, under a much reduced activity, for some months or even years. The treatment has already been outlined: it consists of morphine, small meals of food calculated to produce as little flatulence as possible, moderate limitation of fluid intake, attention to bowel evacuation and, most of all, sufficiently long bed rest and stringent reduction of physical activity after leaving bed.

THOMAS HENSHAW KELLY, M. D. (240 Stockton Street, San Francisco)—I will not attempt to add anything to the excellent presentation of the pathology and symptomatology of coronary occlusion given in the present paper. I would, however, like to speak briefly of the importance of diagnosis and prognosis in this condition and to emphasize the importance of its early recognition.

We, as physicians, serve two purposes, the first that of curators of the sick, and the second that of prophets as to the outcome of nature's and our own efforts in behalf of our patients. It is in the exercise of this second function that we can often do great good, even though our first purpose is foredoomed to an unsuccessful issue.

Coronary occlusion is always a cataclysmic event, and we have not only an exceedingly ill patient upon our hands, but also a family stunned by the sudden terrible affliction of one of its members, and enormously distressed and perturbed by the possible or probable outcome of the attack. I do not need to picture for you the confusion, sorrow, and uncertainty existing in a home after one of its inmates has been visited by such a sudden and violent illness.

In a practice not to be qualified by the adjective "large," two patients have died of coronary occlusion within a year—one four, and the other five days after the onset of the disease. Both cases were recognized early, the suspicious finding being the persistence of the pain after the use of nitrites and ordinary doses of morphine. The patients were not informed of the probabilities, but their families were, and it was remarkable to note the calming effect upon them when certainty was substituted for doubt and they were warned of the inevitable end. We can bring a certain quiet and comfort to troubled hearts and minds when we can speak with certainty of the future, even though that future be fraught with grief. False hopes built upon false opinions lead only to greater stress and sorrow.

Thus it is that I wish to emphasize the need for us to know this lesion in all its phases, that we may not only safeguard our patients, but that we may be of real use to those so near to them and who at such times depend so much upon us and our opinions and advice.

DOCTOR KERR (closing)—The discussion by Doctors Churchill, Gundrum, and Kelly, emphasizes the frequency and importance of coronary disease in practice. If more thorough post-mortem examinations were done, I am sure this condition would be revealed in a great many cases where it is not now suspected, particularly in those cases where individuals die suddenly. In connection with the subject under discussion, it would be advisable to refer to two other papers which have been published since this one was written: Fredrick A. Willius and George E. Brown—Coronary Sclerosis: An Analysis of Eighty-Six Necropsies, American Journal of Medical Sciences, August, 1924; Hermon C. Gordinier—Coronary Arterial Occlusion: A Perfectly Definite Symptom-Complex; The Report of Thirteen Cases With One Autopsy, American Journal of Medical Sciences, August, 1924. These papers add a considerable number of new cases to the literature which is growing rapidly, and is of great value in such studies.

The Early Diagnosis of Joint Tuberculosis—Errors in diagnosis of joint tuberculosis are discussed by Alan DeForest Smith, New York (Journal A. M. A., November 15, 1924). In the first two years of the disease, it always is difficult to make a positive diagnosis of tuberculosis of a joint. The only laboratory test that establishes the diagnosis is guinea-pig inoculation, and this is inconclusive when negative. The condition is obscured in many cases by immobilization before the diagnosis has been proved. The percentage of error in diagnosis of these conditions is high. The mistake of calling a nontuberculous condition tuberculosis probably is just as frequent as the reverse. As a result of the large factor of error in diagnosis, much harm is done to the patients, and the statistics about the results of conservative treatment are misleading. Because of the extreme importance of being certain of the diagnosis, exploratory operation is indicated in all doubtful cases.

FOREIGN BODIES IN THE RESPIRATORY AND UPPER DIGESTIVE TRACTS*

By SIMON JESBERG, M. D., Los Angeles

Deliberate, careful study of the patient must be made.
Symptoms caused by a foreign body depend on its location, size, shape and composition.
All foreign bodies cause suppuration eventually if they are not removed.
Team work is absolutely essential for successful bronchoscopy.
General anesthetics are rarely necessary.

ONE can hardly take up the discussion of modern bronchoscopy without the feeling that most of his words and ideas are borrowed from the works of Chevalier Jackson.

Many dangers and pitfalls surround the amateur bronchoscopist, as his problems are greater than those of one working in a clinic devoted solely to that work. He is often tempted into original modifications of technique—usually to his sorrow. His judgment is being constantly threatened by doctors and relatives of the patient, who demand hasty and immediate removal of the foreign body. It is often a difficult matter to convince them that there is no urgency and that a careful study of the case is much more essential than haste. It is difficult to maintain a trained team, without which consistently good work is impossible, and last but not least, the occasional case brought to him does not offer enough material to keep him in practice.

It is not intended that this paper shall cover completely the technique and problems of pre-oral endoscopy, but rather to present some of the most salient problems and adventures encountered in a series of forty cases. The distally lighted instruments have many advantages over those that are illuminated from reflected light in the handle, such as Breuning's. Visibility is much better, as the light is always on the field of operation and is not intercepted so much by the inserted forcep, as in handle-lighted instruments. Breuning said that actually seeing the action of the grasping forceps was more fancy than fact, and so it is with his instruments; but with Jackson tubes the forcep jaws are always more easily seen. This permits the development of technique and performance not possible when manipulations are largely guided by the sense of touch, as is necessary in Breuning tubes.

The element of luck is always present, but as one progresses he learns to depend not on that fickle lady for success, but rather upon following, rigidly, certain rules. Certain requirements are absolutely essential for the regularly successful handling of foreign body cases. They are:

Deliberate routine study of the case.
Team work.
Proper equipment.
Operative skill and technique.

Deliberate, careful study of the patient must be made. Doctors must be brought to realize that a foreign body is not an emergency, unless the larynx is obstructed, in which case, if suffocation is impending, a tracheotomy should be performed and then time taken to study the situation properly. Fatal injury can easily be done by failure to appreciate the exact problems in a given case, such as location of the point of an open safety pin or the presence of sharp projections on an irregular foreign body. Failure to recognize such a situation is endangering a favorable outcome. Fatal perforation or rupture of the tissues can be avoided by proper appreciation and handling of the individual problem of each individual patient.

A definite history of entrance of the foreign body is usually given. Sometimes, however, the symptoms caused at the time the foreign body enters are too slight to attract attention, and it is only after secondary changes occur, such as lung suppuration or esophagitis, that attention is called to the condition.

Many physicians are slow to consider the possibility of a foreign body unless there is a history of its entrance, notwithstanding that symptoms are present which clearly indicate some unusual condition. Suspicion should be aroused in atypical instances of lung infection and an x-ray examination made. Even with a positive history, there are some who are slow to entertain the possibility of the presence of a foreign body.

Case No. 25 (Plates Nos. 1 and 2)—A 6-year-old girl aspirated a steel ball-bearing, which was allowed to remain in the lung nine months before discovery. Four days after aspirating the ball she developed pneumonia, which the physician failed to connect with the accident. He treated the patient, in consultation with other physicians, for nine months, during which time the child was subjected to rib resection and external drainage of the lung.

Case No. 28 (Plates Nos. 3, 4 and 5)—Carried a large nail in his right bronchus four months because his physician failed to associate his symptoms with the accident. The lung condition failing to clear up, he sent the patient to Arizona for climatic treatment, where an x-ray examination showed the nail.

Apparently more missionary work is still necessary to teach physicians that children do occasionally aspirate foreign bodies and that all atypical lung infections should be examined for this possibility.

Symptoms caused by a foreign body depend on its location, size, shape and composition. Thus a wide range of physical signs is possible. A foreign body in the larynx causes more or less aphonia and cough. In the case of a small foreign body, there is but little obstruction to the air passage. Subsequent edema, however, due to irritation by the intruder, may cause marked obstruction. Often cases with a laryngeal foreign body are diagnosed as croup. This is not surprising when we consider the frequent incidence of croup in young children.

Case No. 23—Had a safety pin in the hypopharynx for six weeks, during which time a variety of diagnoses were under consideration by the pediatric service of a large general hospital. It was only after curiosity was aroused to see what was causing the laryngeal edema that a laryngologist was called in and the foreign body located.

Case No. 30—Had a fragment of walnut shell in the hypopharynx for eight weeks. Even with a positive history of swallowing nut shells, he was under

* Presented to the Section on Eye, Ear, Nose, and Throat at the Fifty-third Annual Session of the California Medical Association, Los Angeles, 1924.

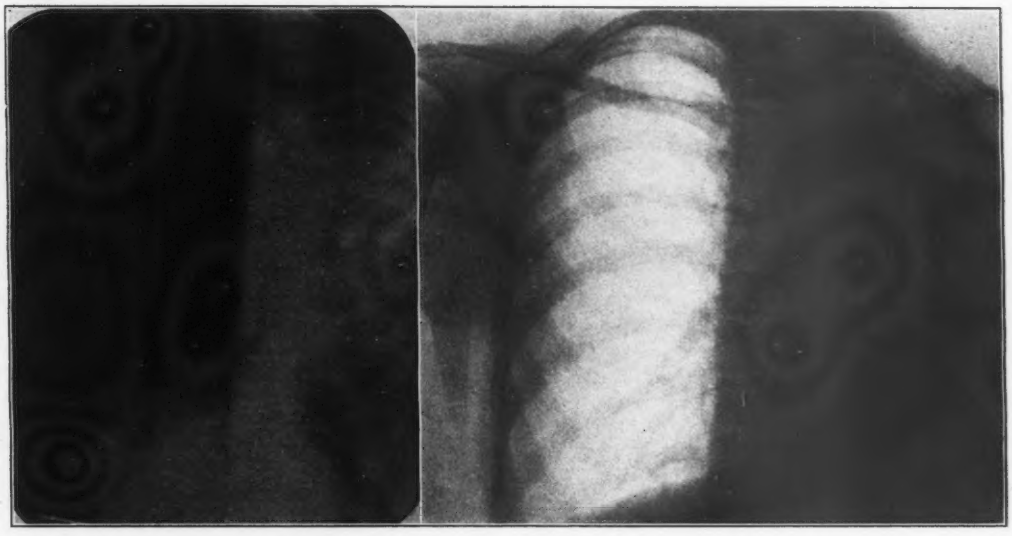


Plate No. 1, Case No. 25—Steel ball-bearing in left bronchus nine months.

Plate No. 2, Case 25—Pathology in lung four years after removal of ball-bearing. Clinically, the child is in good health except for expectoration of thick pus. She requires weekly bronchoscopic aspiration to maintain this condition of health. As soon as lung aspirations are discontinued septic symptoms begin. Postural treatment has been tried with no benefit.

the case of several men before a laryngeal examination was made.

Case No. 5—A 2-year-old baby was practically moribund when first seen by a laryngologist. He had been sick six weeks. A small piece of cancellous bone was found in the larynx. This patient died several hours after removal of the foreign body.

In the trachea, a foreign body causes coughing, particularly when it is moved about by the respiratory air blasts. With a stethoscope over the sternum, the movement of the foreign body can be heard. During forcible expiration, such as coughing, a thud is heard as the foreign body strikes the closed glottis. Tracheal thud was observed in case No. 32, caused by a sunflower seed in the trachea. A foreign body usually does not long remain in the trachea, for, if its size permits, it enters a bronchus and finally travels down as far in the tracheo-bronchial tree as possible. Inflammatory changes in the respiratory tract vary greatly, according to the nature of the foreign body and the degree of obstruction. Certain vegetable substances set up a violent reaction in a few hours. Peanuts and beans are particularly certain to do this. Metallic and wooden bodies usually cause but little reaction for a long time.

All foreign bodies cause suppuration eventually if they are not removed. Swelling of the mucosa about the foreign body aids in obstructing drainage of that part of the lung, which in time results in suppuration. When a bronchus is completely obstructed, atelectasis results. Air trapping occurs as a result of a partially occluded bronchus; i. e., either by a foreign body alone or else by swelling of the mucosa; the lumen is occluded completely during expiration, than during inspiration; the bronchus dilates slightly, permitting air to enter the lung past the obstruction. This results in emphysema of that part of the lung; displaces the neighboring structures; the diaphragm downward and the mediastinal contents to opposite side. This air-trapping is well shown in a radiograph and is a most valuable aid in the detection of non-opaque foreign bodies.

Case No. 35 (Plates Nos. 6 and 7)—A peanut in the right bronchus. This is clearly shown. Radiographs are taken at the end of inspiration and at the end of expiration. The first shows emphysema of both lungs, the second emphysema of the air-trapped lung only, with the diaphragm depressed on that side and the mediastinal contents dislocated to unaffected side.

As suppuration results below an obstructed bronchus, clinical signs of pneumonia, with fever, rapid pulse, rapid respiration and cough are manifested. The breath has a foetid odor and there is profuse expectoration of foul pus. If drainage is not established by removal of the foreign body, tissue destruction results, forming a lung abscess. It is surprising how nature may heal such an abscess after the foreign body is removed.

In case No. 28 (Plate No. 5)—Four months after removal of the nail, the x-ray shows no remnant of lung suppuration. However, these lung suppurations do not always get well spontaneously. In case No. 25 (Plate No. 2) a ball-bearing in the left lung nine months, immediate improvement began after removal of the foreign body, and apparently complete recovery of the lung suppuration occurred in a few months. However, after one year's time, following a cold, suppuration again became active and the patient is still under treatment requiring weekly bronchoscopic aspiration.

A 2-year-old Mexican boy had a lung abscess drained externally. During course of treatment of his chest wound he coughed up a fragment of a walnut. He was discharged from the hospital as cured three months later. Two years later he was

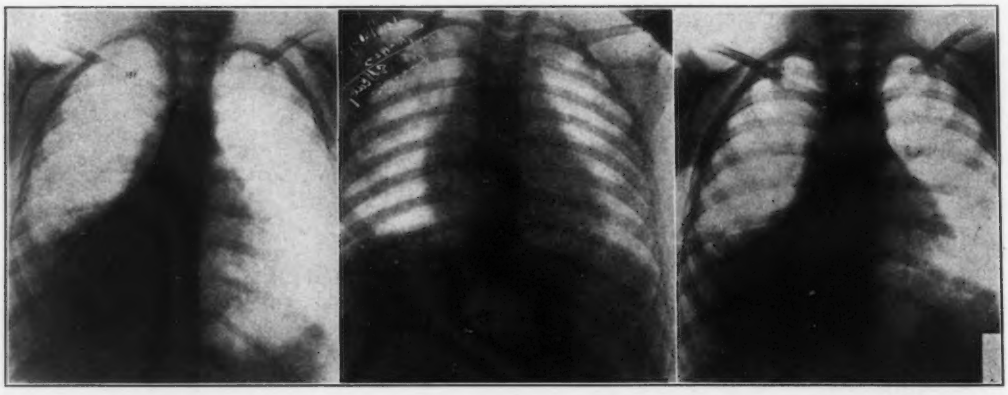


Plate No. 3, Case 28—Nail in right bronchoscope four months. Note lung suppuration.

Plate No. 4, Case 28—Taken twenty-four hours after removal of nail.

Plate No. 5, Case 28 — Taken six months after removal of nail. Note spontaneous recovery of lung suppuration.

under our observation, with extensive lung suppuration, and in spite of repeated bronchoscopic treatments he gradually became worse. The end result of this case is not known for the reason that he passed from my observation and treatments.

Foreign bodies in the esophagus, if they are smooth, and not causing complete obstruction, such as metal discs, may be tolerated for a long period of time with but slight symptoms. Usually there is some difficulty in swallowing solids. If the esophagus is completely occluded, the diagnosis is easily established. Sharp or irregular objects cause injury to the mucosa and inflammation within a short time.

When esophagitis develops, the mucosa is swollen and lumen contains pus which often has a foul odor. Swallowing is very difficult or impossible; pain is extreme; fever and general prostration are marked. Danger of mediastinal infection is impending. Perforation of the esophagus by sharp bodies is not infrequent. If perforation occurs in the cervical esophagus, a neck infection results which usually requires external drainage. Mediastinal infection, resulting either from extension of the neck infection or from a perforation in the lower part of the esophagus, has an extremely high mortality. Three cases of this series were suffering with acute esophagitis, each due to a small bone in the esophagus. All of these had swollen, tender necks, temperature about 102 degrees, and a septic appearance. In addition to the removal of the foreign body, the necks of two of these patients were drained externally. One was drained externally without ever finding the foreign body; the third case had only removal of the foreign body, without external drainage. All three recovered. These are cases No. 3, No. 7 and No. 11 respectively.

The x-ray is of the greatest help in the diagnosis of foreign bodies. No patient should be operated upon without first having had proper x-ray study. If the

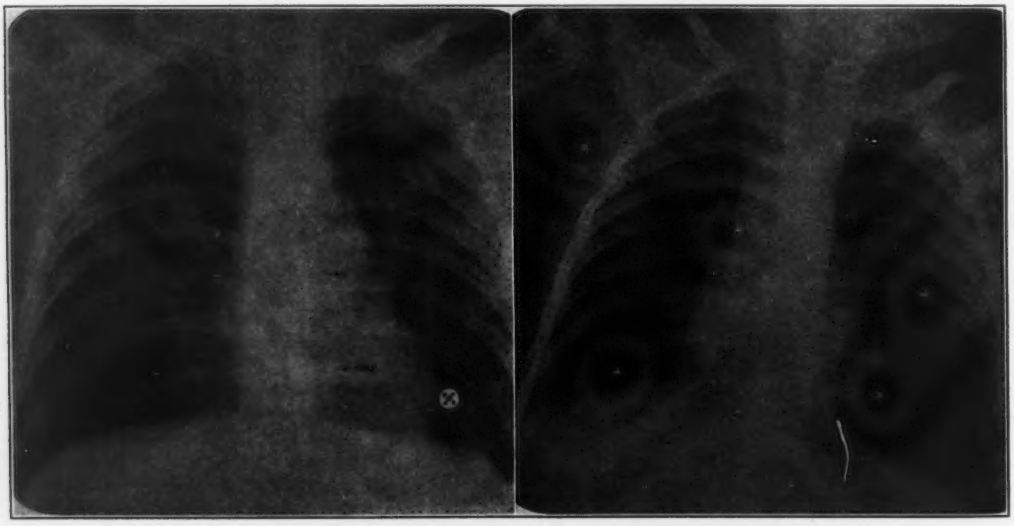


Plate No. 6 and 7, Case No. 35—Peanut in the right bronchus, No. 6 shows air trapping in the right lung, decreased density of the right lung, depression of the right dome of the diaphragm, displacement of the mediastinal contents to the left.

No. 7, taken twenty-four hours after removal of the peanut, shows lung restored to normal.

foreign body is not opaque, the x-ray will be inclined to show a pathological picture indicating the location of the intruder. If the foreign body is opaque, plates taken in different planes show its exact shape and relation to the structures. At least one plate should be taken in a plane showing the longest dimension of the foreign body. Plate No. 8 shows a safety pin in the larynx. The antero-posterior view looks like a closed pin; the lateral plate shows it open, the point below the arytenoids and stuck in the tissue. With this knowledge, it was easy to remove the pin by first freeing the point. Had no x-ray been taken, the situation could not have been recognized, as the keeper end of the pin alone was visible. Traction on the keeper end of the pin could only have succeeded in imbedding the point deeper.

Non-opaque foreign bodies in the esophagus can often be demonstrated with an opaque meal. First: By a filling defect when the esophagus is filled by the opaque meal. Second: Retention of barium about the margins of the foreign body, outlining it after the rest of the barium has passed on.

Team work is absolutely essential for successful bronchoscopy. The most skilled bronchoscopist can not do his work unless he has trained helpers. It is the one who holds the head that has the really important job, and he must perform his work accurately. Failure to recognize this necessity almost always results in failure to introduce the tubes. This is the greatest obstacle encountered by an amateur team, and can be overcome only by development of team work through practice. The person who hands the instruments to the operator must be trained exactly in his duties, as a slight break in his technique may lose a golden moment of opportunity for the operator and turn success into failure.

A third helper is necessary to hold the shoulders down, thereby steadying the patient and permitting the head holder to extend the head properly. Operative skill and technique are acquired by practice only. Cadavers are not good material upon which to gain experience because the greatest difficulties encountered are not anatomical ones, but rather the movements of living tissues. Lung suppuration cases requiring frequent treatments are splendid material to keep one in practice. Case No. 25 (the lung suppuration following a ball-bearing in the lung) has been bronchoscoped at almost weekly intervals for three years. Cases of bronchiectasis are not difficult to find and will appreciate bronchoscopic treatment.

When a foreign body is diagnosed it is of great aid to reproduce the object as nearly as possible; insert it in a rubber tube in the same position as it is in the patient and practice its removal with the selected instruments.

General anesthetics are rarely necessary. They are indicated more often by those less certain of their technique and skill, or where adequate assistance is not available. The more team work and technique are perfected, the less general anesthesia is necessary. Jackson uses no anesthetic nor analgesic in young children. I saw him perform forty-two consecutive endoscopic examinations and treatments without using a general anesthetic. In older children and adults he uses cocain locally. I use butyn in 2 per cent and 5 per cent solutions in all cases. Butyn has been used by me more than 300 times with but one toxic reaction. This occurred in a 4-year-old child that had had the drug used many times before. On this occasion a double dose was given through a misunderstanding. About 4 cc. of 5 per cent butyn was injected into the larynx and trachea. Fifteen minutes later he became cyanotic, frothed at the mouth and lost consciousness; there were several convulsions—the whole phenomenon closely resembling an epileptic fit. Recovery occurred quickly, just as it does in epilepsy. Butyn has been used several times since on this patient without any ill effect.

Plate No. 8, Case No. 22—Safety pin in larynx. With endoscopic view the keeper end alone could be seen. The position of the point was concealed. With information obtained from this radiograph the removal was easily and safely accomplished.

REPORT OF FORTY CASES OF FOREIGN BODY

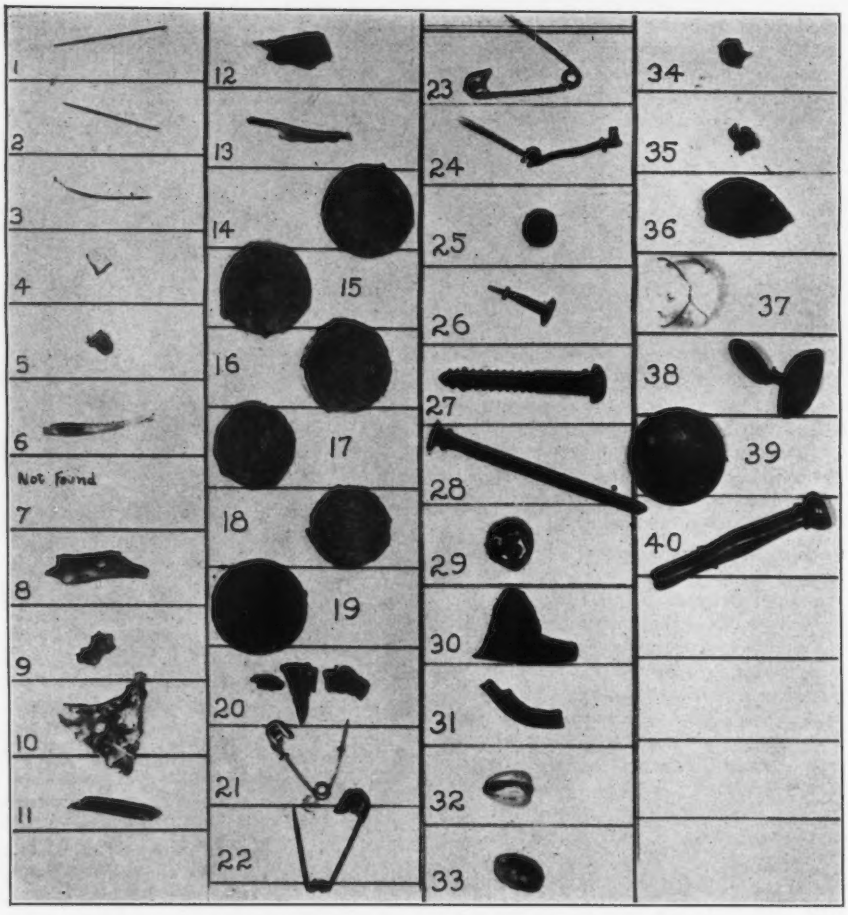
Case 1—William W., male, 24 years. History: Three hours after aspirating pin. Now feels pricking in throat. Indirect inspection shows pin transversely fixed behind epiglottis, point stuck in right side of larynx. Diagnosis: Pin in larynx. Result: Removed with curved forceps, using laryngeal mirror. Indirect method. No anesthetic. August 1, 1922. Recovery.

Case 2—L. L., female, 15 years. History: Five hours before aspirated pin. Indirect inspection shows F. B. in right pyriform sinus. Diagnosis: Pin in larynx. Result: Removed with alligator forceps through Jackson's laryngoscope. No anesthetic, trendelenberg position. Time 10 seconds. June 7, 1923. Recovery.

Case 3—Elizabeth N., female, 11 years. History: Twenty-four hours before swallowed pin. X-ray showed F. B. in left pyriform sinus. Sent to Los Angeles from Calexico; x-ray here shows the pin on right side. Seen by indirect examination. Diagnosis: Pin in right pyriform sinus. Result: Ether anesthetic, Jackson laryngoscope, patient vomited, pin found after prolonged search in epipharynx. Removed. Recovery. June 9, 1920.

Case 4—Betty, female, 15 months, three days ago while playing in fireplace choked; some fragments of wood were removed by the mother from the mouth. Croupy cough and noisy breathing since. No cyanosis. X-ray negative. Diagnosis: Piece of wood in larynx. Course and result: Jackson laryngoscope, no anesthetic. Grasped with alligator forceps, rotated and removed. Kept in hospital twenty-four hours. December 4, 1923. Recovery.

Case 5—Baby F, male, 2 years. Hoarse six weeks, croupy cough with high fever two weeks, marked dyspnea last twenty-four hours. X-ray shows large thymus, otherwise negative, W. B. C. 24,000, temperature 103, respiration 32, pulse 140. Urine shows acetone. Child exhausted. Diagnosis: Bone in larynx. Course and result: Without anesthesia, Jackson laryngoscope and 4 mm. tube, laryngeal edema, small cancellous bone found in



glotis, removed F. B., trachea explored, breathing easier, six hours later collapsed, tracheotomy by intern, died one hour later. December 24, 1922. Died.

Case 6—Mrs. C. H., female, 35 years. Four days before, while eating chicken, felt sharp prick in throat; swallowing painful since; neck swollen twenty-four hours. Unable to swallow. Temperature 102; pulse 112. X-ray shows small shadow below cricoid level. Diagnosis: Chicken bone in esophagus; perforation; neck infection. Course and result: Ether, Breuning tubes and forceps. Intense swelling of esophagus; lumen contains foul pus. Bone two inches below cricoid on posterior wall, transverse, right end penetrates wall. Grasped and removed. Neck opened, external drain inserted to esophagus. Normal in four days. August 20, 1919. Recovery.

Case 7—William B, male 24 years. May 18, 1923. Felt bone swallowed while eating fish. Pricking on swallowing since. Indirect inspection negative. Refuses x-ray May 21. Still feels F. B. X-ray refused. May 22, chill, neck swelling. Painful swallowing. X-rays taken—negative for foreign body. Temperature 100, pulse 104, respiration 22. Neck on left swollen and tender. Diagnosis: Fish bone perforating the esophagus. Neck infection. Course and result: May 22, Butyn 5 per cent. Jackson Ant. Commisure speculum used to explore upper esophagus; also used esophageal speculum. Intense inflammation left side esophagus. F. B. not found. Neck drained externally. May 28 abscess left side esophagus; opened; F. B. not found. 6-2 ether. Almost normal. F. B. not found. May and June, 1923. Recovery.

Case 8—Mrs. A., female, 55 years. History: Painful swallowing twenty-four hours since eating beef stew. X-ray shows shadow level 6 C. V. Diagnosis: Beef bone in esophagus. Course and result: Ether, Jackson 7 mm. tube. Bone found two inches below cricoid level caught in folds of post-wall esophagus, removed. July 1, 1921. Recovery.

Case 9—M. S., male, 11 months. Six hours ago while playing on the floor suddenly choked and coughed, became cyanotic, soon normal. Repeated attacks of coughing and cyanosis, vomiting at times, blood-streaked vomitus. X-ray—No shadow; shows emphysema right lung. Diagnosis: Rabbit bone in right bronchus. Course and result: Ether, Jackson 4 mm. tube, bone found in right bronchus. Grasped and removed. Moderate laryngeal edema two days. Kept in hospital four days. September 4, 1920. Recovery.

Case 10—J. C., male 48 years. Last night was eating chicken, felt bone being swallowed, has dull sub-sternal pain since, worse on swallowing. Fluids and solids pass, but he is afraid to swallow. X-ray shows no shadow; after barium, shadow is outlined, 3 inches above diaphragm. Diagnosis: Flat chicken bone in lower esophagus. Course and result: Ether, Jackson 10 mm. Esophagoscope. Bone found 37 cm. from incisor teeth. Sharp projection caught in mucosa, grasped with rotation forceps, freed and removed. Normal after recovery from ether. May 29, 1923. Recovery.

Case 11—J. E., female, 45 years. History: Three days ago, while eating fish, felt sharp prick in throat, painful swallowing since, pain increased past twenty-four hours. Temperature 101, pulse 100, neck slightly swollen and tender. X-ray shows shadow in esophagus. Diagnosis: Fish bone in esophagus. Course and result: Ether, Breuning tube. Bone found in esophagus three inches below cricoid level. Mucosa markedly inflamed and swollen. Bone grasped. On withdrawal of tube and forceps, F. B. slipped from grasp. Further search failed to find it. Patient vomited on return to bed; bone found in vomitus. November 10, 1920. Recovery.

Case 12—Mrs. Q. B., female, 46 years. History: Seventy-two hours ago swallowed piece of bone while eating mutton stew. Painful swallowing since, unable to swallow even fluids forty-eight hours. Temperature 101. X-ray shows shadow level sternal notch. Diagnosis: Mutton bone in esophagus. Esophagitis. Course and result: Ether, Breuning tubes. Mucosa esophagus, red and swollen, pus in lumen. Complete esophagus searched twenty minutes before seeing foreign body. Bone found embedded in swollen mucosa; grasped and removed. Normal in two days. December 12, 1921. Recovery.

Case 13—Mrs. J. L., female, 32 years. History: Two days ago while eating chicken felt prick in throat, painful swallowing since. X-ray shows shadow after barium. Diagnosis: Chicken bone in esophagus. Course and result: Ether. Lynah esophagoscope. Foreign body found just below cricoid fold on post wall of esophagus. Little inflammation. Removed. Time, 90 seconds. December 5, 1922. Recovery.

Case 14—J. E., female, 5 years. History: Nine days

before swallowed nickel. Able to swallow liquids without pain. Four days later family doctor worked one and one-half hours under ether using forceps blindly. Since then painful swallowing. Temperature 100. Case observed four days before removal F. B. X-ray shows opaque shadow level 5th cv. Diagnosis: Nickel in esophagus. Course and result: No anesthetic, Jackson 5 mm. tube. Evidence of trauma, hypo pharynx and esophagus. Coin easily found and removed. Time 2 minutes. October 30, 1922. Recovery.

Case 15—Baby W., male, 22 months. History: Three days ago swallowed coin. Able to take liquids; gags at times. Temperature normal. X-ray shows coin in cervical esophagus. Diagnosis: Nickel in esophagus. Course and result: No anesthetic, Jackson 5 mm. tube. Coin seen and removed. Time 90 seconds. October 24, 1922. Recovery.

Case 16—H. B., female, 2 years. History: Child has been gagging three days, unable to swallow solids. X-ray, round opaque shadow in upper esophagus. Diagnosis: Nickel in esophagus. Course and result: No anesthetic, borrowed equipment, two casual assistants. After one hour's hard work managed to see coin; finally was dislodged, passing down into stomach; passed in stool next day. September 20, 1916. Recovery.

Case 17—L. S., male, 3 years. History: Two days ago swallowed penny; able to swallow only liquids. Temperature normal. X-ray shows coin. Diagnosis: Penny in esophagus. Course and result: No anesthetic, Jackson 5 mm. tube. Removed in less than two minutes. July 20, 1923. Recovery.

Case 18—W. J., male, 14 months. History: Child swallowed coin three days ago, will not swallow past twenty-four hours. Temperature 99 rectum. X-ray shows coin. Diagnosis: Penny in esophagus. Course and result: No anesthetic, Jackson child's esophageal speculum, alligator forceps. Removed in twenty seconds. March 16, 1924. Recovery.

Case 19—L. M., male, 2 years. Four weeks difficulty in swallowing, retches, able to swallow liquids easily. Temperature 100. X-ray shows shadow in cervical esophagus. Diagnosis: Metal disc from electric switch-box in esophagus. Course and result: No anesthetic, Jackson 5 mm. tube. Esophagus mucosa inflamed. F. B. found and grasped and easily removed. Time 3 minutes. July 20, 1923. Recovery.

Case 20—F. A., female, 9 years. History: Today playing in school yard, aspirated piece of metal she carried in mouth; lost voice at once, gagged and coughed. Breathing slightly obstructed. Child has the habit of swallowing metal bits, pins, nails, etc. This is first time any were aspirated. Temperature 102, respiration 24, pulse 120. X-ray shows shadow in larynx. Diagnosis: Metal curl from latheing tool steel in larynx. Course and result: Ether, Breuning laryngoscope inserted through glottis. F. B. seen below cords firmly impacted. With alligator forceps, lateral arms broken off and removed. Laryngeal edema and temperature two days. Normal in four days. November 20, 1920. Recovery.

Case 21—R. G., male, 6 months. History: Child has been gagging three hours. When this began mother missed a safety pin, put finger in baby's mouth, felt pin, unable to remove it. Fluoroscope shows pin, open, point up, to right level xyphoid. Diagnosis: Safety pin in esophagus. Course and result: No anesthetic, Jackson 4 mm. tube. Trachea and bronchi searched, no F. B. Tube passed in esophagus; pin found at lower end, point embedded in mucosa, keeper end grasped and drawn into tube. Removed. Time 30 minutes. February 24, 1922. Recovery.

Case 22—M. H., female, 6 years. History: Six hours ago aspirated safety pin, aphonia since. Diagnosis: Safety pin in larynx. Course and result: No anesthetic, Jackson child's laryngoscope. Keeper alone visible in glottis, grasped and pushed forward and down, freeing point. Removed. Time 30 seconds. April 17, 1924. Recovery.

Case 23—J. A., male, 10 months. History: Entered L. A. C. H. November 3, 1921. History of impaired respiration six weeks. Both parents positive Wasserman, child negative Wass. Culture for diphtheria negative. X-ray shows large thymus. General examination negative. Takes liquids with difficulty, breathing labored, noisy. Weight 11 pounds 11 ounces. Direct laryngoscope shows safety pin in hypo pharynx. X-ray of neck shows open pin, point up and to right. Diagnosis: Safety pin in hypo pharynx. Course and result: No anesthetic, Jackson infant's laryngoscope. Pin found in hypo pharynx, grasped with alligator forceps, point liberated. Removed. November 23, 1921. Recovery.

Case 24—A. P., female, 11 months. History: Three days ago began to cough and gag, constant cough since, fever two days. Roentgenologist examined under fluoroscope, reports pin in esophagus, level 5-7-D.V. Plate not taken. Pin found in right bronchus. Diagnosis: Beauty pin in right bronchus. Course and result: Ether, Breuning 4 mm. tube, taking fluoroscope. Esophagus explored, no F. B. Fluoroscope still shows F. B. Pin found in right bronchus, point in trachea. Point brought in tube, grasped and removed. Edema larynx, fever three days. Time 1 hour 20 minutes. July 13, 1919. Recovery.

Case 25—E. B., female, 7 years. History: January 3, 1920, developed pneumonia, told attending doctor that she swallowed large ball-bearing four days before. Eight weeks later, rib resection for empyema, no pus found. Three days later began to expectorate foul pus. Thoracotomy wound suddenly discharged pus, rapid emaciation, clubbing fingers, chest wound closed. August 27, 1920, x-ray shows ball in left bronchus, lung abscess. Diagnosis: Steel ball-bearing in left bronchus, lung abscess. Course and result: Ether, Jackson 5 mm. tube, specially bent double cusp Breuning forceps. Much foul pus removed by suction. Granulations obstruct lumen, left lung. Ball felt in left bronchus, grasped, removed with tube, lost at glottis. Further search failed to find ball. Return to bed, ball vomited. Gained twenty pounds in forty days. Sputum free in two months. Later recurrence, still under treatment. August 31, 1920. Recovery.

Case 26—M. D., female, 2½ years. History: Two days ago swallowed carpet tack. Mother became alarmed as stools did not contain tack. X-ray showed tack in right bronchus. Temperature normal. Diagnosis: Tack in right bronchus. Course and result: No anesthetic, Jackson 5 mm. tube, side-grasping forceps. Point grasped, drawn into tube and removed tube. Time 2 minutes. July 1, 1922. Recovery.

Case 27—D. M., male, 12 years. History: May 5, 1923, aspirated screw. May 6, under ether one hour, local doctor attempted removal with bronchoscope. Brought to Los Angeles May 7. Temperature 101, respiration 30. X-ray shows large wood screw in right bronchus. Observed three days; temperature subsided. Diagnosis: Screw in right bronchus. Course and result: Butyn 5 per cent, Jackson 7 mm. tube, side-grasping forceps. Screw easily found, grasped and removed with tube. Time 4 minutes. No post-operative reaction. May 10, 1923. Recovery.

Case 28—C. M., male, 4 years. History: February 1, 1923, swallowed six-penny nail; four days later developed pneumonia; attending doctor refused to consider nail history. Fever gradually subsided, cough persisted, foul expectoration, emaciation. Moved to Arizona for T. B. X-ray June 20, 1923, showed nail in right bronchus with lung suppuration. Diagnosis: Nail in right bronchus. Course and result: Butyn 5 per cent, Jackson 5 mm. tube, side-grasping forceps. Nail found, extending into trachea from right bronchus, foul pus. Nail grasped and removed. X-ray of chest four months later shows no pathology of lungs. May 1, 1923. Recovery.

Case 29—H., male, 49 years. History: Three days ago dentist gave gas to extract crowned third molar. Tooth broke off and was lost down throat. X-ray showed crown in right bronchus. Patient has had pulmonary T. B. Diagnosis: Gold crown in right bronchus. Course and result: On August 18, 1922, Bronings' instruments, Dr. B. worked one hour, cocain anesthetic, sitting position, unable to grasp tooth. August 19, 1922, Jackson 9 mm. tube, Boyce position, tooth removed in 4 minutes, rotation forceps. August 19, 1922. Recovery.

Case 30—R. S., male, 15 months. History: Six weeks ago was playing with walnut shells; gagged and vomited. Mother gave castor oil. Fragments of nutshell in stool. Breathing noisy. Takes fluids, Fever one week. Local doctor advised adenoidectomy. Temperature 100, pulse 120, respiration 24. Chest examination negative. X-ray shows no F. B. Diagnosis: Piece walnut shell in hypo pharynx. Course and result: Chloroform, Jackson infants' laryngoscope. Intense inflammation, granulations, swollen tissue. Shell found in hypo pharynx, grasped with alligator forceps, rotated and slowly removed. Child normal in few days. March 2, 1920. Recovery.

Case 31—R. M., male, 2 years. History: One and one-half hours ago, eating walnuts, choked and coughed; aphonia and labored breathing since. X-ray negative. Diagnosis: Walnut shell in larynx. Course and result: No anesthetic. Jackson child's laryngoscope. Shell found wedged in glottis, grasped with alligator forceps, rotated and slowly removed. Kept under observation twenty-four hours. Time 40 seconds. January 30, 1924. Recovery.

Case 32—K. P., female, 3½ years. History: May 13, 1923, eating sunflower seeds, choked, cyanos at times, cough. Entered L. A. G. H. May 14. Labored breathing. Temperature 101. "Tracheal thud" present. X-ray negative. Diagnosis: Sunflower seed in trachea. Course and result: No anesthetic, casual assistants. Unable to introduce tube (poor exposure larynx); laryngeal edema increased. Tracheotomy. Seed coughed through tracheal wound. Broncho pneumonia developed May 14, 1923.

Case 33—H. J., male, 17 months. History: Three hours ago choked and became cyanotic while playing with beans. Hypertympany over right chest; absent breath sounds over right chest. Diagnosis: Bean in right bronchus. Course and result: No anesthetic. Jackson 4 mm. tube, Breuning double-hook forceps. Bean found in right bronchus, grasped and removed with tube. Time 3 minutes. Was allowed to go home. Twelve hours later laryngeal edema. Tracheotomy not permitted by parents. Atropin given; better. Sudden cyanosis and death fourteen hours after operation. April 8, 1922. Died.

Case 34—E. L., female, 18 months. History: Six days ago playing on the floor, choked and became cyanotic; four days later, cough, temperature 102, rapid respirations. Continued fever since. At L. A. G. H., F. B. diagnosed. X-ray shows air trapped, right lung. Diagnosis: Almond kernel in right bronchus. Course and result: Butyn 5 per cent, Jackson 4 m., tube. Mucosa right bronchus, swollen; nut fragment found and removed. Laryngeal edema increased; tracheotomy required in forty-eight hours. Tracheal tube removed in one week. December 21, 1923. Recovery.

Case 35—I. J., female, 16 months. History: Four days ago while eating peanut candy, choked and coughed. Forty-eight hours later temperature 102, pulse 120, at

L. A. G. H. Air trapped right lung, demonstrated with x-ray. Diagnosis: Peanut in right bronchus. Course and result: Butyn 5 per cent, Jackson 4 mm. tube. Fragment of nut kernel found in right bronchus; mucosa swollen; removed. Time, 4 minutes. Normal in four days. September 12, 1922. Recovery.

Case 36—F. W. F., male, 45 years. History: Five days ago while eating plum pudding, had sudden, complete obstruction to swallowing. At 18 years of age had esophageal obstruction due to lye; treated by dilation. X-ray shows filling defect at diaphragm. Diagnosis: Plum pit in esophagus. Course and result: Ether, Breuning's tube. Esophagus narrowed, old scars. F. B. found, grasped and removed to cricoid, where it slipped from forceps. Further search unsuccessful. Able to swallow for twenty-four hours, when complete obstruction again occurred. F. B. again found and removed. August 8, 1920. Recovery.

Case 37—C. S., male, 12 years. History: Three days ago swallowed marble; complete obstruction to swallowing since; no pain or other symptoms. X-ray shows shadow level 6 d. v. Diagnosis: Marble in esophagus. Course and result: Butyn 5 per cent, Jackson 7 mm. tube, spoon. Unable to grasp F. B. It was pushed into stomach; passed in stool next day. November 20, 1922. Recovery.

Case 38—M. M., female, 2 years. History: This morning child swallowed a large cuff button; choked, became cyanotic. X-ray taken two hours later shows cuff button in thorax. Diagnosed by roentgenologist as in trachea. Child has frequent colds and tonsillitis; two days has had a cold. Diagnosis: Cuff button in esophagus. Course and result: Butyn anesthetic, diagnosis accepted from x-ray report—plates not seen by operator. Bronchoscopic search; no foreign body; trachea inflamed; edema larynx. F. B. found in esophagus; pushed into stomach; passed in stool ten hours later. Laryngeal edema increased. Tracheotomy necessary. December 16, 1923. Recovery.

Case 39—J. W., male, 20 months. History: Difficulty in swallowing thirty-six hours. X-ray shows no F. B. Temperature normal. Diagnosis: Coat button in esophagus. Course and result. Butyn 5 per cent. F. B. seen tightly wedged in esophagus three inches below cricoid. Ether given. F. B. loosened and removed. June 13, 1923. Recovery.

Case 40—A. A., female, 5 years. History: While being treated with intubation for laryngeal stenosis, aspirated O'Dwyer tube. X-ray shows tube in left bronchus. Diagnosis: O'Dwyer intubation in left bronchus. Course and result: Butyn 5 per cent, Jackson 5 mm. tube. Expanding forceps inserted in lumen of tube. Removed F. B. August 16, 1922. Recovery.

DISCUSSION

Chester H. Bowers, M. D. (1136 West Sixth Street, Los Angeles)—Dr. Jesberg is extremely fortunate in being able to present so many cases of foreign bodies in the respiratory and digestive tracts with such favorable outcome. It is highly desirable that such papers be brought to the attention of the general profession, as even today there is current among some of our number the belief that a foreign body is a very rare thing and that if it occurs there is nothing to be done.

Two years ago I removed a rivet after seven months' sojourn from the posterior division of the right inferior lobe bronchus. Although the boy gave the history of aspiration of the foreign body, the parents were informed that the rivet would not go down into the lung, and if it should it would be safer to let it remain than to encounter the danger of removal. Removing the rivet caused no reaction, but cured the child from a lung abscess which had formed.

Another point that the essayist made is to guard against hasty removal of foreign bodies.

The removal of foreign bodies is seldom an emergency operation, and I feel that it is a serious mistake to operate until the case has been properly studied, the exact location of the foreign body determined, the team assembled and the patient properly prepared. Personally I prefer doing these operations early in the morning in contradistinction to rushing about all day in an effort to wildly extract the foreign body at the soonest moment. These are factors which are apparent to every bronchoscopist, but are not generally appreciated by the medical profession.

George W. McCoy, M. D. (Security Building, Los Angeles)—This line of work is a specialty within itself, handicapped by not sufficient revenue to afford a living for the operator and his team workers. About all the financial returns in the majority of cases is the coin removed, and sometimes the patient is offended to give that up. With few exceptions the operator has to make his living by other work and to make this line practically charity work. The laity nor the medical profession in general do not appreciate the great amount of time and practice necessary to do good work. Without the careful procedure so thoroughly worked out by Jackson, without the requisite skill by the operator and his team workers, the attempt at removal of a foreign body should not be made.

Dr. Jesberg is to be honored that he devotes so much of his time to this work and does it so skillfully.

I would like to report two interesting cases.

A child about 3 years of age had a few pennies in his mouth. X-ray showed one distinct shadow and a faint one somewhat overlapping in the esophagus as if the patient might have moved or there were two pennies. I did not know which. Two pennies with one grasp of the forceps were removed, without anesthetic and without the slightest damage.

A boy about 13 years of age, while running with a silver-plated collar button in his mouth, choked somewhat when the collar button went down. X-rays were taken and reported negative. For about fourteen years the young man coughed and expectorated a muco-purulent sputum and then he reported to Dr. Soiland, who made the proper diagnosis by x-ray and sent the patient to me. At the end of the lowest branch of the right bronchus was an almost closed abscess about two and a half inches in diameter with a small opening surrounded by a firm fibrous ring so small that Jackson's forceps would just pass through. Three separate attempts were made at about one month intervals with local anesthetic to the pharynx and larynx. By the use of Jackson's bronchoscope and the fluroscope to direct the forceps the button was removed without any mishap. In a short time the muco-purulent expectoration and cough disappeared. X-ray showed the abscess gone. The patient resumed his collegiate studies. Dr. Detling, who worked with me on this case, and I were greatly pleased. The collar button had about half disappeared by chemical reaction.

Harvard McNaught, M. D. (Butler Building, San Francisco)—I have enjoyed Dr. Jesberg's excellent and timely paper, and wish to congratulate him on the results of his careful work.

We have all had these problems to meet in this work, and one must be more resourceful in this procedure than in any other branch of surgery, as entirely new situations are continually presenting themselves. Preparedness is a sine qua non of this work, and haste is very seldom called for. The thing that is brought most forcibly to my mind at this time is that some one man or group of men should be given these cases in each vicinity. No one man has enough of such patients to acquire the necessary dexterity.

Where there is a teaching institution they should have a complete equipment for such work, and it would be logical to refer cases there. It is subjecting the patients to unnecessary risks to hold such cases oneself, unless one is constantly in practice. If all cases were so referred in a neighborhood to one man or a group of men the number would be sufficient to keep them in training to do the best for the patient by acquiring the necessary dexterity in handling such cases.

Problem of Health Education—Health education in our schools is receiving a lot of attention on the part of educators, and we are not disposed to condemn the idea, but we are opposed to the kind of health education that is being given out by a lot of school teachers who are proselytizing for the Christian Scientists, chiropractors, and other medical pretenders. All health education in our schools ought to be under the supervision of health officers who are reputable medical men, and not given by teachers who have fantastic and inconsistent ideas concerning health and its preservation.—Indiana Medical Journal.

THE TREATMENT OF FLEXION DEFORMITY OF THE HIP JOINT

By S. F. STEWART, M. D., Los Angeles

In a partially paralyzed individual suffering from a flexion contraction of the thigh, an attempt should be made to preserve as much muscle-power as possible for future use.

Where the tensor fascia remains active, it should not be divided transversely as in the operation of Soutter, but should be lengthened in its tendinous portion, and the transplantation of the lesser gluteals after the manner of Campbell should be held as a reserve measure.

DISCUSSION *by Harold H. Hitchcock, Oakland; H. W. Spiers, Los Angeles; A. Gottlieb, Los Angeles; Ethan H. Smith, San Francisco.*

FLEXION deformity at the hip may be due to disease of the bones or joints, or a contracture of the soft parts. It may be simple or associated with abduction or adduction. The deformity due to bony lesions will not be considered in this paper. The contracture of the soft parts results chiefly from improper prophylaxis in poliomyelitis, spastic paraplegias, arthritis, and the retention of an amputation stump in a faulty position for an unwarranted period.

If the distortion is unilateral and very marked, the unfortunate usually prefers to use a crutch, making no attempt to place his foot on the ground. A slight or moderate bilateral contracture is compatible with biped progression if the paralysis of the remaining musculature is not too severe. Campbell states that, if the bilateral contracture is greater than 60 degrees, the individual is compelled to assume the quadriped form of locomotion. In some unilateral cases, where the person has permitted the affected member to dangle, it has been observed that there is marked shortening of the bones of both the upper and lower leg. After the deformity has been corrected and the person begins to use the leg, a compensatory growth apparently begins.

Soutter, in 1914, described an operation which, in its essential features, consisted in the exposure of the deep fascia of the thigh at the level of the anterior spine, a transverse division of the tensor fascia from the anterior superior spine to the trochanter, a sub-periosteal stripping of the inner and outer aspect of the ilium and the removal of the anterior superior spine. This operation gave a great deal of satisfaction. Campbell, in 1923, described a more radical procedure, wherein the gluteal attachments to the iliac crest are transferred to a point about an inch above the acetabulum, and the structures attached to the anterior superior spine were permitted to attach at a more inferior position.

These operations work very well in selected cases, but there is a group of cases to which neither procedure is applicable. It would, therefore, seem wise to evaluate the groups to which each operation is applicable. In the operation described by Soutter, there is frequently a division of manifestly good muscle in the belly of the tensor fascia femoris at the time that the overlying fascia is divided transversely. It is a well-recognized fact that the transverse division of the belly of a muscle weakens the muscle in proportion to the amount of muscle separated from its nerve supply. Hence, it would appear inadvisable to perform the Soutter operation on any individual who showed any power in the tensor fascia femoris and in whom it might be advisable at a later time to transplant the tensor fascia to take the place of the quadriceps femoris or the gluteus medius.

It is likewise patent that when an elastic structure, such as a muscle, is on tension between two points of attachment, that the shortening of the distance between these two points reduces the tension exerted and likewise reduces the range of contractibility, and thereby amounts to a partial paralysis of the muscle. This, in short, is what is accomplished by the operation as described by Campbell, in case there is any power left in the glutei which he transplants.

If, therefore, an operative procedure can be devised which will avoid destruction of the tensor fascia even in a slight degree, and which will retain whatever power remains in the lesser gluteals, and yet permit of the correction of the flexed or the flexed and abducted position of the thigh, it would seem wise to use such a procedure in all cases where power in the tensor fascia and the gluteals can be demonstrated.

Therefore, it would seem proper to review briefly the physiological anatomy of the affected region, and endeavor to indicate the methods of differentiating the various groups. The tensor fascia femoris is the lateral stabilizer of the pelvis when the thigh is flexed, as in walking upstairs; the lesser gluteals, on the other hand, are the lateral stabilizers when the thigh is extended, as in ordinary walking. By the same token they may be demonstrated on examination, respectively, as the abductor of the hip in flexion, and the abductors of the hip in extension. If, therefore, the patient can abduct the thigh while it is in a flexed position, it would seem reasonable to believe that the tensor fascia was present to a greater or less degree, and an attempt should be made to avoid the partial destruction of that muscle by the transverse division of some of its fibers at the level of the anterior superior spine. With a hip drawn up in flexion, it is impossible to evaluate the lesser gluteal muscles, and hence it would seem unwise to weaken them unnecessarily by such an operation as that of Campbell, who believes that where the abduction contracture is great that the operation which he has described is the one of choice. On the other hand, it is our belief that, in orthopedic surgery, one should be governed by the following principle, that when in doubt, always do the least radical thing, knowing that if it does not yield the desired results, the more radical procedure can be undertaken at any time. To avoid these objections, the following operation has been devised. A longitudinal incision is made from the iliac crest to a point one inch below the level of the perineum, and about one and a half inches posterior to the anterior superior spine. The deep fascia is exposed and freed from the overlying tissues till the anterior and posterior borders of the tensor fascia femoris are exposed. The muscle is then isolated from the anterior superior spine to the level of the perineum where the fleshy belly of the muscle terminates. The fascia is divided by a "Z" incision, as is done in lengthening the tenso-Achilles, and the fascia is sutured in the

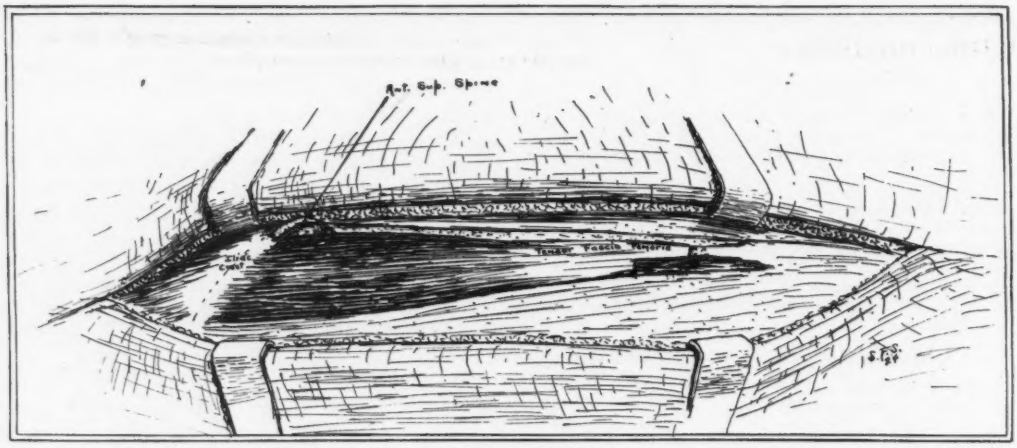


Figure 1—Showing the point of lengthening of tensor fascia femoris, together with the loosening of muscle from the anterior superior spine.

lengthened position. The periosteum over the anterior superior spine is incised and the periosteum is stripped on the inner and outer sides of the pelvis, as in the manner of Soutter. The leg is drawn back into an extended position, and any tight fibers that remain are cut transversely. The wound is then closed, a simple dressing applied, and the patient is returned to the ward.

Although no difficulty has been experienced in the after care of patients treated by this operation, the unfortunate results that have attended immediate hyperextension in plaster jackets in the hands of other surgeons has led to the adoption of the following technique in the after care. Ten days later, when the stitches are removed, a snugly fitting plaster jacket, or jacket spica of the unoperated leg, is applied with the back in the flattened position, and the operated leg is enclosed in a long plaster boot. The patient is then placed on a frame that was described in a previous communication, and the limb gradually hyperextended. The abduction or adduction element is taken care of by lateral traction on the plaster boot. After being hyperextended for a period of six weeks, the plaster is removed and any further operative procedures are undertaken. In the event that one is now unable to correct the abduction element in the deformity, one can then with a clear conscience undertake the operation of Campbell, although in the half-dozen or more cases in which this operation has been done no occasion has been found that required further operative correction. If, after the patient is gotten up and has had his muscle-training it is found that there is a gluteus medius limp, an unimpaired tensor fascia can be transferred to the trochanter after the manner of Legg.

SUMMARY

In a partially paralyzed individual suffering from a flexion contraction of the thigh, an attempt should be made to preserve as much muscle power as possible for future use. To this end, in cases where the tensor fascia remains active, it should not be divided transversely as in the operation of Soutter, but should be lengthened in its tendinous portion, and the transplantation of the lesser gluteals after the manner of Campbell should be held as a reserve measure.

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DISCUSSION

Harold H. Hitchcock, M. D. (Medical Building, Oakland)—The tensor fascia latae muscle is supplied by a branch of the superior gluteal nerve which passes through the gluteus medius muscle to the upper third of the tensor fascia latae, and then extends distally from this point, supplying the deep surface of the muscle with small rami.

It is thus obvious, as pointed out by Doctor Stewart, that it is a needless waste of muscle tissue to cut this muscle through its belly. In all cases where one is apt to need the tensor fascia latae for transplant later, I think Stewart has taught us economy. However, in cases of flexion resulting from spastic paraplegia, I would prefer the procedure of Soutter.

For his frame and for this lesson in muscle economy, to aid the correction of these hip flexion cases, Stewart is to be congratulated.

Too much emphasis cannot be placed on the dangers of trying to hyperextend hip flexion cases immediately after operation, especially by the application of plaster of paris spicas.

H. W. Spiers, M. D. (Westlake Professional Building, Los Angeles)—Doctor Stewart has pointed out a refinement of value in cases where the Soutter operation has been previously routinely used. The tensor fascia femoris muscle can frequently be made of use to the individual with paralysis in the gluteal region. It is quite frequently the only muscle not to some extent affected by the paralysis. I have seen several of the doctor's cases in which he has preserved this muscle and later used it. These showed the distinct advantage of the method.

Regarding the immediate post-operative use of fixed hyperextension, I would like to add my word of caution. Until I adopted the plan of not putting on such casts, I rather dreaded the post-operative reaction of my patients. I avoided using this operation, on this basis, in patients that presented an unusual operative risk. There were no fatalities, but I had several in a series which gave me very considerable concern. I am now using, routinely, the method as described, and my experience in this regard has been very satisfactory.

A. Gottlieb, M. D. (607 South Hill Street, Los Angeles)—It has been my good fortune to assist the author in three of his operations for the lengthening of the tensor femoris fascia, and to follow the cases post-operatively. The operation impresses one with its simplicity and its sound physiological judgment that the greatest contracture is present in the fascia and not in the muscle substance, the resistance of which can be overcome by subsequent physiotherapy. It is the fascia which needs elongation, and not the muscle which is being cut across by the method of Soutter to gain the necessary correction of the hip. The favorable

results seen in the above three cases leads me to believe that the Stewart operation is indicated in most all hip flexions due to contracted soft tissues. An exception to this may only be such cases where the operator deliberately desires to destroy nerves supplying the muscle substance, as in marked spasticity where the Soutter may be preferable or where there is, in addition to flexion, a very resistant abduction of the hip, for which a Campbell procedure may find indication. The Stewart operation, with its outlined after treatment, is indeed a valuable contribution to orthopedic surgery.

Ethan H. Smith, M. D. (Flood Building, San Francisco)—The operations mentioned by Doctor Stewart for flexion deformities of the hip-joint such as Soutter's and Campbell's, and a modification by Doctor Stewart himself, have a very limited range of usefulness, in my opinion, if indicated at all.

From a study of the action of the hip-joint, it would seem that the muscles involved in the above-mentioned operations are in but a small measure to blame for the deformity. The muscles most involved are the psoas and iliacus with the combined tendon attached to the lesser trochanter, which is the direct flexor of the thigh. Almost invariably the adducter group is also greatly contracted in these cases. The tendons of the psoas and iliacus muscles are well-nigh inaccessible for extensive operation. Tenotomy of the adductors is a very simple and a very useful procedure in many cases where they are contractured.

The cutting transversely of the body of a muscle, and especially the muscles involved in the operations under discussion, is never warranted by any compensatory improvement in function. The transverse cutting of a muscle is well-nigh uncalled for in any surgical procedure. The psoas and iliacus muscles can nearly always be lengthened by traction. They are not prone to contracture.

To use a popular way of expression, the best method of cure is the prevention of deformity in the beginning of the trouble. This is quite possible if the cases are placed in the hands of surgeons trained in orthopedic work right at the beginning. I would ask that every influence be brought to bear on the medical profession as a whole, to pay more heed to turning these cases of deformity, and many others, over to the orthopedic surgeons just as soon as a diagnosis is made. Telling parents that "the child will outgrow the trouble," or wasting valuable time in useless and unskillful endeavor, brings the case to the orthopedic surgeon in a condition when perfect cure is impossible.

Doctor Stewart (closing)—I would like to take issue with Doctor Smith in two matters, first in regard to the responsibility of the psoas and iliacus in causing flexion deformity. I have never seen a case of contracture at the hip where these muscles were responsible, and I believe my memory is correct when I say that the late Doctor Robert W. Lovett told me he had never seen a case of flexion contracture in which operative measures were necessary on the ilio psoas group. When such a careful observer, and one who had such a large experience in the treatment of these conditions could say that, I doubt very much whether many cases are due to this group of muscles.

As to the responsibility of the adductors, I can only say that adductor contraction is rarely present in infantile paralysis, but is frequently responsible for a portion of the deformity in spastic paralysis and in arthritic conditions.

In the next place, I feel that Dr. Smith is rather radically conservative in advising traction for the removal of the severe deformities of the hip in infantile paralysis. If he were confining his remarks to arthritic conditions of the hip, I would heartily agree with him in the use of traction. In the paralytic contracture, however, I must disagree with him. For many years Soutter endeavored to treat these conditions by non-operative procedures, only to meet with disappointment, and it was these unfortunate experiences that finally compelled him to devise and practice the operation which bears his name. My endeavor has been limited to an attempt to add a refinement of conservatism to the pioneer work of Soutter.

I thoroughly agree with the plea for preventive orthopedics, especially in infantile paralysis.

RATIONAL CONDUCT OF LABOR

By HARRY S. FIST, M. D., Los Angeles

Physician must know what should be done and what left undone.
A plea for physiologic midwifery.
Much of present surgery in obstetrics unwarranted.
The physician's services should date from early pregnancy to complete involution of the uterus.
The lazy doctor should not do obstetrics.

DISCUSSION *by E. J. Krahulik, Los Angeles; John Vruwink, Los Angeles; Elizabeth Keys, San Francisco; G. Carl H. McPheeters, Fresno.*

THE modern physician has a regrettable tendency toward the use of complicated and involved methods for the accomplishment of plain and simple tasks. The obstetrician is no exception.

The older generation of obstetricians would tie the umbilical cord with a piece of sterile tape, and the result was satisfactory. The newer generation must needs have some sort of a special clamp or technique for performance of the same task. All manner of bizarre maneuvers are advocated and used to deliver the child, when a simple procedure assisting the mechanism of labor would effect delivery. It is a glaring fact that, in spite of all our efforts, the relative mortality rate for parturient women, as the result of sepsis, has not materially diminished in the last twenty-five years.

Something seems to be wrong with our work. Obstetric patients require care from the time of conception to the end of involution. Why do they not obtain it? Delivering the baby is by no means the whole story. The ultimate aim is to have a well mother and a well baby.

PRENATAL

A careful history and a complete examination, instructions as to diet, care of breasts, exercise, clothing, and coitus, are essential in every case. Examinations of urine and of blood pressure at frequent intervals are of the utmost importance.

Previous to the onset of labor, the pelvis and its contents should be studied carefully and the findings recorded. The shape and size of the pelvis should be known, and a pre-labor study made of the position, presentation, and size of the fetus, especially the head.

George Ernest Herman goes so far as to state in his book, "Difficult Labor," "Almost all difficult labors are the result of faulty diagnosis, not only of the position of the fetus, but also of disproportion between the size of the fetus and the size of the pelvis."

LABOR

If labor is to be attended efficiently, it is necessary to know the anatomy of the birth canal and to understand the share each structure has in the mechanism of labor. With this knowledge, the forces nature intended will be applied, instead of the present-day spectacular makeshifts. No matter how careful our aseptic precautions, we endanger the patient's life every time we invade the birth canal. Statistics show that 40 per cent of all fatal septic cases have had some sort of operative interference. How much better it would be if we could more often terminate labor without the performance of

version or the application of fearfully and wonderfully designed forceps, for mother and baby would then both be in less danger. The dangers of a breech presentation may often be avoided by external version prior to the onset of labor. Induction of labor, because of a borderline pelvis, may render a Caesarian section unnecessary.

FIRST STAGE

The uterine contractions are in the upper uterine segment. The lower uterine segment dilates as the upper contracts and retracts, pulling the lower against the presenting part, aided by the hydrostatic pressure of the bag of waters. The child cannot be expelled until the cervix is fully dilated. Clearly, then, the patient should not bear down during the first stage of labor, for the presenting part, surrounded by the lower segment, would be wedged into the pelvis, and dilatation thus retarded. The patient would tire herself out without making any progress. The supports of the uterus would be pulled down, laying the foundation for "falling of the womb," at a later date.

It is possible to know the condition of the cervix, and the progress of the presenting part, by means of rectal examinations at intervals. Until the cervix is fully dilated the patient should not bear down, and should rest between pains. She should have light, easily assimilable food at regular times, and sedatives if indicated.

SECOND STAGE

The second stage of labor is one of active work. The responsibility for this stage rests entirely with the doctor. The man who goes to bed and has the nurse call him when the head is being born is in a class with the midwife; for, if he has the knowledge, he is not at hand to apply it. Worse than the lazy man is the one who unnecessarily invades the birth canal, for he increases the danger of infection, and the patient would be much better off without him.

The bag of waters protects the child and helps dilate the cervix. When the cervix is fully dilated, if the membranes are not already ruptured, this should now be done, or progress is impeded.

In this stage the patient should assist every pain with voluntary efforts, and should receive instructions from the doctor so that she may know how best to do so. If she does not assist, contractions often become weak or die away entirely. If she is reassured and urged to further efforts, to simulate straining at stool, to work throughout the entire course of every pain, and to rest between pains, labor will proceed much better. When pains are tumultuous and labor too precipitate, the patient should refrain from bearing down, or be given a sufficient amount of anesthetic to retard the pains.

In order for delivery to take place, the fetal presenting part must flex, descend into the pelvic cavity, and flex further at the pelvic floor, when rotation and delivery follow.

If flexion does not take place, labor stops. This is, in most cases, due to the inability of the uterine and abdominal muscles to exert enough pressure. Therefore, some method for assisting these muscles to produce flexion of the presenting part seems the logical procedure. The tight abdominal binder, as used by Beck of Brooklyn, does the work very well. In its simplest form, this binder is a piece of strong cloth, pinned tightly around the abdomen with safety pins. It may be made as a front and a back piece, with buckles and straps on each side. With this support, the patient can exert more pressure, so that flexion takes place and labor proceeds, saving the mother and baby hours of stress and danger. In cases of pendulous abdomen, the effect of the binder is often magical.

"Puller-straps," are helpful. They should be short enough so the patient need not bend the elbows, but can pull straight from the shoulders.

During the second stage, the fetal heart should be carefully checked after every pain by means of the head stethescope. If slower than 100 per minute, faster than 160 per minute, irregular, or failing to return quickly to normal after each pain, it is a sign of too much compression of the child. The appearance of meconium with a vertex presentation also indicates danger. Upon the development of any of these signs, the binder should be removed and the patient asked to cease all voluntary efforts until the heart is normal, after which more caution is used as to the pressure applied.

A lacerated or relaxed perineum does not flex the head well so that rotation will follow, and has lost the funnel-shape which is so important in directing the occiput forward. It is, therefore, very often a great factor in delayed rotation. Steps should be taken to restore such a perineum to as nearly its normal function as possible. To accomplish this, the thighs should be flexed tightly on the abdomen during each pain, when the head is on the perineum. This tightens the perineum much as the same process would tighten the seat of a man's trousers. As a result, the head flexes, rotation takes place, and many a so-called persistent occiput posterior is avoided. Why, then, attempt forceps extraction or methods of rotation which involve invasion of the uterus, before trying this simple procedure? The mother and baby are entitled to all the safety we can give them.

When the head begins to come through the vulva, the patient should be given sufficient anesthesia to cause partial subsidence of pains; the thighs should be extended to relax the perineum, and a hand placed over the head, slowing its progress and directing it forward against the pubes.

As soon as the head is delivered, search should be made for coils of the cord about the neck. These may be brought up over the head, or slipped down over the shoulder. If neither can be done, two clamps may be applied and the cord cut between them.

The head should be depressed, so the anterior shoulder will slip out under the pubic bone. The head should then be elevated, and the posterior shoulder will pass out over the pelvic floor. Since the bulk is decreased by the anterior shoulder being out of the way, there is less chance of causing a laceration. The rest of the body easily follows.

Mention of the fact that the bowels and bladder should be empty, and that strict aseptic and antiseptic precautions should be observed, seems unnecessary; but the sad fact remains that many obstetricians disregard these important things. The feasibility of forceps extraction, version, or Caesa-

rian section, is always considered; but the necessary practical procedures which are at our command are dismissed without a thought.

THIRD STAGE

From the time the baby is born until the placenta is expelled, the assistant or nurse should keep one hand on the fundus and gently rub its surface if there is relaxation. There is no especial hurry about delivery of the placenta, so the baby may first be taken care of. It should be made to breathe properly, first milking out the trachea with the finger on the front of the neck, and then stimulating respiration by running the hand quickly up and down the spine. The baby should never be struck over the kidneys. It is well at this time for the doctor to cleanse the face and place the prophylactic in the eyes. The cord may be tied when it stops pulsating, and a sterile alcohol dressing and binder applied.

If, at the end of twenty minutes, signs of separation of the placenta are evident, the thumb may be placed in front of the uterus, the four fingers behind, and the two brought gently together to assist expulsion. Manual removal of the placenta should be regarded as a major operation. The cord should never be used for traction. The placenta should always be examined to see that it is complete.

At the end of the third stage, the cervix is usually low in the pelvis. The large veins brought with it are kinked and stretched, so the tendency is toward congestion and hemorrhage of the uterus. By means of one or both hands, applied above the pubes, the uterus can be brought up into the abdomen, lessening the danger of hemorrhage and increasing the chances of ultimate proper position of the uterus. At this time the patient may be given ergot or pituitrin, and the uterus should be watched for at least another hour.

Examination of the cervix and perineum may be made at once or after an interval of seven days, but, in every case, all lacerations should be repaired.

PUERPERIUM

The duties of the obstetrician are not ended when the uterus is emptied. The patient should be seen daily during the lying-in period. Careful attention must be paid to the diet, the breasts, the temperature, the bowels, the lochia, the uterus, and many other details. Properly directed exercise will do a great deal toward hastening good involution. The baby must have the same sort of care as to abnormalities, umbilicus, prepuce, tongue, bowels, weight, eyes, and numerous other things.

Every conscientious obstetrician will insist on making a thorough examination of mother and baby about a month after the delivery so that he may administer whatever treatment is necessary. If this is done, there is no excuse for leaving uncorrected a malposition of the uterus, or neglecting a badly bulging umbilicus.

SUMMARY

Prenatal care, including complete examination for every patient.

Proper preparation for labor.

Rest during first stage; hard work, and protect maternal structures during second; ample time during third.

When cervix fully dilated: rupture membranes; tight abdominal binder; properly adjusted pullers; flexion of thighs. Close check on condition of baby.

Replacement of uterus after expulsion of placenta.

Post-partum care, to include examination one month after delivery.

Westlake Professional Building.

DISCUSSION

E. J. Krahulik, M. D. (6422 Hollywood Boulevard, Los Angeles)—Dr. Fist's plea for physiological obstetrics, at a time when operative delivery is the fashion, should be commended. At present little attention is directed toward the first stage. Sad experience has taught us that attempts at delivery before the cervix is fully dilated are mutilating and often disastrous. The various interferences have, therefore, been postponed to the second stage.

One needs to remain with but a few women during their labor, and he will realize that the second stage is relatively comfortable. When the cervix is fully dilated, one can safely predict a termination within two hours. Three or four drops of chloroform properly administered with each pain will make the patient comfortable. I am familiar with a labor routine similar to the one described which is used by Polak at the Long Island College Hospital, Brooklyn. Forceps are rarely necessary, second stages usually terminate within two hours, and there is little anxiety about posterior positions. The head does not rotate until it reaches the levators, consequently there is little cause for alarm before the cervix is dilated. If at this time there is someone present to direct the patient's efforts, such misfortunes as deep transverse arrest and unrotated posteriors will be historical.

Does the obstetrician who performs a version or applies forceps unnecessarily blame himself for his invalids, as well as his deaths? Does the hour of labor that the patient has avoided sufficiently compensate for the possibility of years of discomfort from a chronic parametrial inflammation, and later for an operation when some hopeful gynecologist will sacrifice a cervix and perhaps a normal tube and ovary trying to cure this pain? When these conditions do occur and one has not done any operative procedures, "the peace of mind surpasseth all understanding."

Our conservative efforts should be directed to the first stage. It is most unmercifully neglected. Usually the patient is allowed to suffer alone in a room. Occasionally a nurse or the doctor stops long enough to tell the patient that "she must help herself," and instructs her to "bear down." How grateful a patient is when someone remains with her to comfort and encourage her. A noisy patient becomes calm and will rest between pains. Knitting or reading magazines are hardly outbursts of sympathy.

Analgesia during the first stage is still a glaring field for investigators. An analgesic must be fool-proof and must not carry any possibilities of complications. Where it is not contra-indicated because of the patient's general condition, gas will alleviate the suffering. It is practically harmless, but rather expensive. Morphine scopolamine may be used safely by trained obstetricians when there is an ample pelvis, but increases the incidence of forceps. The man who promiscuously promises a painless labor is dangerous.

Contracted pelves with a diagonal conjugate of 10 cm. or above should be given a test of labor; that is, a second stage of at least four hours managed as outlined by Dr. Fist. Should the head fail to engage, a two-flap low-incision Caesarian section could then be performed. In a series of cases where this plan was followed, borderline and flat pelves occurred about fifty-five times per thousand, but the incidence of Caesarians was only 0.8 per cent. Inducing borderline pelves would require many unnecessary inductions; some cases might not be induced in time, others would give very small babies.

John Vruwink, M. D. (Pacific Mutual Building, Los Angeles)—Two years in a mining camp in Arizona afforded me an opportunity to watch the immediate results in about five hundred labors. The patients were, for the most part, Mexicans. There was practically no prenatal care, the management of labor consisted, in general, in conducting the second stage. The outstanding fact in my mind was the high proportion of spontaneous labors, the

total absence of eclampsia, the absolute rarity of sepsis, and post-partum hemorrhage.

This was an interesting comparison to a series of cases followed at the Chicago Lying-in Hospital, where the conduct of labor was one of activity in the second stage, namely, prophylactic forceps.

The habitat and life of the woman in the open and her increased capacity for work and pain were no small factors, in the matter of comparison, to the artificialities surrounding the life of the patient in a large city.

The Los Angeles Maternity Service is now conducting more than 100 labors per month. Since its inception the slogan has been "Intelligent Watchful Expectancy." A maternal mortality of one death to 734 deliveries and an infant mortality of less than 5 per cent, including all stillbirths and deaths within ten days, is more than presumptive evidence that we should continue this course.

The end-result, as Dr. Fist emphatically states, is a well mother and a live and normal baby. Such a result is obtainable not merely by conservative management, but conservative management intelligently applied. We will always face the possibilities of hemorrhage, there is disproportion between passenger and passage, not always discernible before labor, and there is sepsis even in spontaneous labor, with no examination or interference. Occasionally, an eclampsia occurs, in spite of judicious management, because of our imperfect knowledge of its etiology.

I do not believe that the midwifery practiced in Arizona equals in results, particularly for the mothers, the end-results obtained in later observations. Neither do I believe that forceps—or version and extraction—may be indiscriminately applied, and that results can approximate the end-result of normal spontaneous labor, intelligently directed according to the principles of this paper. No one, however, who sees much consultation practice can hide the fact that conservative obstetrics ceases to be intelligent conservatism when factors are present or arise during the management of labor causing dystocia. A plea for conservative obstetrics is equally a plea for intelligent interference.

Dr. Fist is to be decidedly encouraged in his plea for rationalism, more attention to prenatal care; more thoughtfulness for the first stage of labor; more intelligent management of the second and third stages of labor; and watchfulness during the puerperium, both for mother and baby.

Elizabeth Keys, M. D. (391 Sutter Street, San Francisco)—Discussion of obstetrical subjects has so tended to the spectacular that the physiological phases of pregnancy and delivery must risk lack of savor. It seems a pity that with so many fundamental problems still untouched, time, labor, and interest should be spent on more or less dramatic detail.

Prenatal care means that at all stages of pregnancy the doctor has a clear picture in his mind of the mother, her baby and their reaction to each other. While safe-guarding the patient, this also greatly relieves the physician of the sickening terror of the unexpected, an experience that may visit the most careful in a fulminating toxemia or sudden violent hemorrhage.

Prenatal care means also attention to all the small details of the patient's life, common sense hygiene, explanation of discomforts, reassurance oft repeated, neighborly experience and advice modified or utilized, morale sustained—and *only on indication* does it mean radical departure from the patient's ordinary mode of life.

It is unnecessary to discuss further Dr. Fist's presentation of the mechanics of labor, but we cannot resist emphasizing his picture of the risks of the vaginal finger. To our mind the greatest (in fact, the only great) advance in childbed prophylaxis in many years is the development of rectal examination, yet some of our interns come to us completely unacquainted with this procedure, and many men who are doing only casual obstetrics will not take the pains to develop their judgment in this important item of diagnostic technique.

That bete noir of the obstetrician, the posterior position, is ever-occurring. With added years of observation, we find many suggestive symptoms in the labor when the case has not been clear on abdominal examination; both first and second stages are slow with varying pains, rectal examination shows persistence of the anterior cervical lip, which does not retract readily over the imperfectly flexed head, and descent is sluggish. Encourage those patients, perhaps give them a rest with morphine and chloral and bromide, and allow them time for nature's effort at rotation, which is usually less damaging than radical interference.

We are doubtful that any method of support at the outlet is really valuable. After delivering several hundreds of Japanese primiparae with but rarely a stitch, and hundreds of whites rarely without one, we feel convinced that it is a matter of tissue rather than technique; and this opinion takes into account the relative size of mother and baby.

During the third stage we insist on *gentle* manipulation of the uterus, no abuse in the name of Crede. Also when the placenta is lying in the posterior vagina (as evidenced by the fundus, discharge of the retroplacental blood and slackening cord) it can be lifted out by tension on the cord much more safely and humanely than by driving it out from above.

The delivery of our women is largely in the hands of the general practitioner and will remain so. Therefore, an important factor in the "Rational Conduct of Labor" is the technical training of our interns in all the pathology of the maternity service. Since they are sent out at the end of their intern year, authorized to practice a branch of medicine that has such a proportion of true emergencies there should be no reservations on the maternity service. A breech in the hospital, under the eye of a chief, is much better experience than a breech later without help. All the complications of delivery and the puerperium should, with the assistance of the chief or assistant, contribute directly to the technical skill of the young graduate, leaving the specialist to annex as private assistant the young man who plans to limit his work and perfect himself in it.

G. Carl H. McPheeters, M. D. (Mattei Building, Fresno, California)—After reading and re-reading Dr. Fist's very interesting paper, I wish to say that I am in complete accord with the methods which he uses. For years I have employed the thorough physical examination for women before pregnancy, early in pregnancy, and examination of the expectant mother before labor begins. I never employ vaginal examination during the last month of gestation, but rectal touch only.

Care of the breasts of the primipara will well repay the physician, as well as his patient. We advise gentle finger massage of the entire breast to increase the circulation of the glands during the entire pregnancy. We advise traction of the nipples and the use of 10 per cent glycerite of tannin once daily, to toughen the nipples during the last month before the birth.

I especially approve of Dr. Fist's practice of keeping the patient quiet and having her avoid voluntary effort during the first stage. Many patients exhaust themselves by useless straining and bearing down during the first stage, and inertia develops during the second stage at the very time when voluntary efforts are necessary for normal birth. We also discourage the patient from walking about the room during her first stage. For the very nervous patient we employ codein grains ½ hypo. during the first stage, using morphine grain ⅓ or ⅙ for the very frightened and hysterical patient.

It is my practice to continue post-partum care for six weeks, and to examine every mother and baby at the end of six weeks. The ancient knee-chest posture and the hard ring pessary still have their field of practical use in preventing and correcting post-partum retroversions.

We have to thank Dr. Fist for a very interesting and practical monograph.

Slandering a Medical Man—To have and to maintain a good reputation is a matter of very great and serious concern to a physician, and he ought to give thoughtful and careful attention to the best means of protecting it against those who wantonly or wickedly seek to detract from it. Doctors are a frequent subject of gossip, but when it tends to damage them they should remember that it is not always defamatory, and that, indeed, they often derive substantial benefit from it. Ordinary foolish gossip should be altogether ignored, even though it be irritating and unfair, since by dealing with it seriously as a slander, wide publicity may be given to it and people may be led to infer that it is founded on something substantial when, as a matter of fact, it is mere irresponsible chatter.—Medical Standard.

AN UNUSUAL CASE OF PYLORIC STENOSIS

CASE REPORT

By ALANSON WEEKS, M. D., *San Francisco,* and LEROY BROOKS, M. D., *San Francisco*

THIS case is reported because it is unusual, in that the child developed the disease, was operated upon and had recovered before the time it normally should have been born, and to emphasize again the value of surgery when it is indicated. We have not lost one of these babies in the last twenty upon whom we have done the Fredet operation. We repeat again the importance of early recognition and proper care, in order that these patients do not come to operation starved and dehydrated, as has been the custom too often.

K. W. entered Children's Hospital June 22, 1924, for Doctor Langley Porter. The following history, elicited from the mother, was typical of congenital pyloric stenosis, as far as the disease is concerned.

The boy was born May 18, 1924, two months premature, and weighed three and three-quarter pounds. He retained foods well at first and had normal bowel movements. He began to vomit his food on June 17, 1924. After that he regurgitated part or all of every feeding, regardless of what he was given. Vomiting for the last few days before entrance into the hospital was at times projectile in character. The stools became less frequent and finally he had none at all for several days. Enemas were returned with very small amounts of fecal matter. He was very much dehydrated and weighed only four pounds.

Inspection revealed the typical small lower and large upper abdomen of this disease. Definite peristaltic waves could be seen to pass from the fundus to the pyloric end of the stomach.

Doctor Porter elected to try thick feedings to possibly avoid operation, and at the same time gave fluids, both subcutaneously and intraperitoneally. The patient improved under this treatment for a few days, when he began again to vomit. The temperature was 101 to 102 daily, but the baby was some better because of the fluids. Doctor Porter advised operation, which was done on July 1, 1924.

The usual Fredet operation, as previously discussed by us in CALIFORNIA AND WESTERN MEDICINE, was performed.

The patient was given four ounces of 3 per cent glucose solution beneath the skin in the axilla and the groin before leaving the operating-room. He received a rectal drip of 3 per cent glucose and 3 per cent soda solution, which is our routine practice in all these cases, and Doctor Porter started the baby's feedings three hours after the operation, giving him first 3 per cent glucose solution and gradually working him back to his standard formula.

The baby had a hazardous convalescence, the temperature rising to 106 F. three days after the operation. This daily rise of temperature gradually subsided and the patient was discharged July 20, weighing five pounds, and was in excellent condition.

He was readmitted July 31, 1924, because the mother stated the baby had a cold. Since leaving the hospital he had five or six normal stools per day. Upon readmittance his respirations were rapid, breath-sounds diminished in the right axilla, and there was diminished resonance over the right lobe posteriorly. X-ray showed pneumonia in the right middle lobe. He ran an irregular temperature from normal to 102 for ten or twelve days.

On August 8 he became very cyanotic. His pulse was about 60 and respiration shallow. He rallied from this attack after a few hours, and coughed up considerable rusty sputum which had a foul odor. After this attack he coughed considerably, and had other attacks of cyanosis, less severe, usually accompanied with cough and expectoration.

On September 5, fluoroscopic examination showed a pneumothorax of the right chest extending from the second rib to the diaphragm and filling the posterior two-thirds of the anterior posterior diameter of the chest. His attacks of cyanosis gradually decreased in number and he began to gain weight.

During his second stay in the hospital his abdomen would frequently become very greatly distended and a mass was discovered in the right inguinal region, which proved to be an easily reducible right inguinal hernia.

The patient was discharged the second time from the hospital on September 18, weighing eight pounds and two ounces and was in good condition. Doctor Porter tells us that he was in his office about October 11, and was in perfect condition.

We feel that this case is rather remarkable, in that it shows the surprising resistance of these little patients if they are furnished with plenty of fluids and glucose. Just why his temperature went to 106 three days after the operation is impossible to say. Doctor Porter feels confident that the pneumothorax was due to a suppurating mediastinal or bronchial lymph gland breaking through into the trachea or large bronchus. This would explain the symptoms of cyanosis and expectoration of foul material, as well as the pneumothorax.

It is very interesting that many of these little patients who were formerly operated upon are now cured by thick feeding. We believe that it is justifiable for the pediatrician to try thick feedings and supply the infant with plenty of fluids and 3 per cent glucose solution before an operation is advised. This would, of course, vary with the circumstances of each individual case.

There is no question that the thick-feeding treatment, if started early enough, prevents one-third of these babies from being operated upon. Our explanation of the action is that, because of the consistency of the thicker food, the hypertrophied muscles of the stomach are able to contract around it and force some through the pylorus like a bougie gradually dilating the canal, where more fluid foods are promptly shot back toward the cardiac end of the stomach.

We would like at this time to report in our series the second mother who has had two babies with congenital pyloric stenosis, both operated upon and cured. We some time ago reported another mother who had had four babies, three of whom had this disease, were operated upon and all three recovered.

380 Post Street.

EDITORIALS

PRACTICING MEDICINE BY MAIL

A situation which can be honestly defined only by calling it the practice of medicine by mail is becoming serious. Strong competition between magazines with large circulations, particularly those widely read by women and children, and *who use their mail order medical departments to get subscribers,* is changing what was formerly helpful health advice into the practice of medicine.

Some of these magazines not only advertise their medical departments conducted by mail, but through obvious sources secure the names of new mothers whom they bombard with circulars and other appeals to join their medical organization which they operate under one name or another. They do not stop at this, but go back to reports of marriage licenses and begin on the new bride and provide "all the health advice she needs." After the baby is born, she not only gets stereotyped medical service for herself, but for the baby as well.

Carefully and wisely prepared informative literature about health and disease given wide publicity is helpful and should be encouraged. Even wisely directed correspondence is deserving of commendation. But the highly commercialized and dangerous practice of medicine by mail as now being conducted by several extensively read publications ought to be condemned.

Several physicians who limit their work to the care of children have reported to us pathetic instances of the result of this sort of propaganda. Some mothers worry themselves sick trying to decide what to do as between the divergent advice and instructions of the family physician and that furnished from one to three or more magazines engaged in the practice of medicine by mail. One mother recently showed her physician three entirely different sets of instructions as to what to do for her three months' old baby with indigestion and vomiting. These instructions were from the "baby experts" of three different magazines, and were sent from an eastern city.

The pediatrician's greatest problem formerly was to neutralize the superstitions of "grandmothers." He thought this a hard problem, but it was nothing to that of the modern pediatrician in overcoming the fifty-seven varieties of unwise advice the present-day mother receives. The chief sources are from paternal government, national, state and local, from women's and children's magazines and other commercial enterprises, and by more personal contact with many varieties of technicians who often go beyond their legitimate field. These are some of the reasons for "forgotten" or delayed birth reports.

Many physicians, either of their own volition or by specific request of a mother, are not enthusiastic in providing "prospect lists" for the dozens of commercial influences that hover over the newspapers and government offices to secure promptly addresses of newly married couples and of births.

THE EFFECT OF MATERNAL SYPHILIS ON THE DEATH OF THE CHILD

Working under arrangements provided by the British Medical Research Council, Doctor Cruickshank has carried out a series of carefully conducted observations in Glasgow to determine the influence of maternal syphilis on child mortality.

From 9 to 10 per cent of unselected mothers from a general hospital service gave positive Wassermann reactions. These figures correspond to similar ones from other centers. They are, of course, somewhat higher than they would be among the population in general. In 94 per cent of the Cruickshank series, the Wassermann reaction in the child at birth corresponded with that of the mother.

One striking result of the study was that the percentage of abortions due to death of the fetus was apparently no greater among syphilitic mothers than others. Stillbirths, however, were 18 plus per cent among syphilitic mothers as against 15 plus per cent among others. The incidence of premature births was 32 plus per cent among syphilitic mothers as against 19 plus per cent of others. Among those children who could be followed up, it was found that the infant mortality was considerably higher among the infants of syphilitic mothers.

This group of infants and young children help to swell the lists of those diagnosed as "malnutrition" and "anemia" by inadequate methods.

The most interesting feature of Cruickshank's work is that, by the most painstaking studies, he confirms the conclusions arrived at by others.

DOCTOR, HEAL THYSELF

Doctor, is your health good? How do you know it is? Do you practice what you preach by having your own periodic medical examinations?

The chances are that you don't. The chances are nine out of ten that a careful examination by one of your colleagues would uncover one or several conditions that you ought to have remedied and which if left alone may cause serious harm. You know this to be a fact. Then why do you procrastinate? Isn't the answer precisely that which is applicable to other citizens? It is, and this explains why it is not more health education most of the world needs, but more gumption. *The knowing and the doing about health or any other question are two different things. The doing is the one generally neglected.*

A person of moderate intelligence who makes a practice of *doing* has a far greater chance of living longer, happier, and more usefully than has the best-informed physician who *knows,* but *does not.* **Think it over, doctor, and either be a doer about your own health or don't complain about your patients who know because you told them so, but who fail to do for precisely the same reasons that are applicable to yourself.**

The Pennsylvania Medical Association is trying to persuade its members to have medical service of the kind its members are advising their patients to have. It is providing the service.

They have arranged to offer examination service to members as one of the features of their annual meetings, notes the editor of the Atlantic Medical Journal. "Twenty of the leading physicians of the

State and County Medical Societies, Attention

THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION PASSED THE FOLLOWING VERY IMPORTANT RESOLUTION AT THE 1924 SESSION:

"WHEREAS, PERIODIC MEDICAL EXAMINATIONS OF ALL THE PEOPLE FROM BIRTH TO DEATH ARE OF GREAT IMPORTANCE IN THE PROMOTION OF HEALTH; THEREFORE, BE IT

"RESOLVED, THAT STATE AND COUNTY MEDICAL SOCIETIES BE URGED TO ENDORSE AS A PART OF THE HEALTH PROGRAM OF ORGANIZED MEDICINE THE MAKING OF THESE EXAMINATIONS:

"THAT THE MEMBERS OF THE RESPECTIVE SOCIETIES BE REQUESTED TO MAKE SUCH EXAMINATIONS IN THE HOMES OR IN THEIR OFFICES, FREE TO ANY PERSONS, WHO, BY REASON OF ECONOMIC CONDITIONS, REQUIRE SUCH FAVORABLE CONSIDERATION, AND

"THAT IN THE PERFORMANCE OF THE WORK THE SAME SYMPATHETIC, CONFIDENTIAL RELATION BE MAINTAINED BETWEEN PHYSICIAN AND PATIENT OR FAMILY AS HAS EVER CHARACTERIZED THE EFFORTS OF TRUE PHYSICIANS."

state have consented to make these examinations. Each will be made in the office of one of the doctors in Reading. The result of the examination will be entirely confidential. The doctor volunteering must think he is well. He will send his name in to the secretary as a volunteer. He will receive a history blank, which he will fill in, putting thereto an examination of his urine, bearing on protein, specific gravity, sugar, roughly total 24-hour quantity. He will receive an appointment from the doctor to whom he is assigned, with a given date and hour, preferably on the first day of the meeting, the street and office number being set forth.

"This examination will be made at a given date and hour, and thereafter the examiner and the one examined will have a brief consultation as to how the examination could be bettered, as to how the history blank could be improved, as to how best this whole subject can be put to the profession in such wise that it will be generally adopted. The one examined will have excluded, insofar as this can be done, a hidden menace to his health. He will have demonstrated a method of examination which he is free to criticize. He will get home better prepared to carry out the general policy."

The only difficulty about the service is that of persuading the doctors to avail themselves of the opportunity.

Is it more "education" or more "gumption" that is needed?

MORE MAIL-ORDER DOCTORS

A non-medical concern, with headquarters in Chicago, is circularizing citizens and inviting paid membership in their longer living, stay well, periodic health examination, medicine by mail, plan. Their advertising matter forms a basis of inquiries from readers of Better Health Service and from both doctors and their patients. A San Francisco business man recently received a batch of this propaganda and turned it over to his physician (Harry Alderson), who in turn forwarded it to CALIFORNIA AND WESTERN MEDICINE for comment. The organization in question claims to be the original one in the personal practice—for a fee—of preventive medicine and life extension by periodic health examinations.

There is a "medical director," and emphasis is placed upon the fact that he is a member of the Illinois Medical Association and the American Medical Association. He is presumably, therefore, an educated physician licensed to practice in Illinois. The advertising literature is not overly specific as to just what are the duties and responsibilities of the "medical director" in supervision of the laboratory work and in making the "copyrighted explanatory key and helpful suggestion" so "confidentially" supplied to the patients.

The propaganda is specific when it says: *"Our medical director gives on each report personal remarks upon your physical condition, and while we do not treat nor diagnose, we are always willing and ready to help our subscribers by writing a personal letter, advising them of the significance of the findings."*

Again, in discussing the great value of the California patients' records in the central office in Chicago, the propaganda says that *"reference to them so often enables our medical director, in his comparisons, to note approaching trouble in time for it to be corrected by the simple means suggested in our reports."*

This health-by-mail service, consisting essentially in a quarterly urine examination of old specimens sent by mail to Chicago, claims that only 5 per cent of 5000 patients had normal urine and that 2223 "subscribers" (patients) were "made normal" (cured) "through attention to our helpful suggestions." The patients of this medicine-by-mail organization are said to reside in all parts of the United States and Canada. The claim is also made that physicians endorse their SERVICE "when they understand there is no treatment connected with the bureau." Immediately following this sentence is a statement of a physician to the effect that "health insurance is coming and . . . the medical profession might just as well make up their minds to swallow it."

After all, "there is more than one way to skin a cat."

CHECKING UP ON DIAGNOSES

It is good for all of us to occasionally have a check-up on the reliability and accuracy of our diagnoses. This is best done by comparing clinical diag-

noses with autopsy diagnoses in a large series of cases.

The best, most complete and most significant study of this kind yet made is that recently reported (Journal of the Philippine Islands' Medical Association) by A. G. and A. B. M. Sison of Manila. Conditions were particularly favorable for the study. The medical college, hospital research laboratories, and city morgue are all upon the same campus. They are all operated under one administrative authority. The records of the college and hospital are unusually complete, well co-ordinated, and the faculty of the school is ex-officio the staff of the hospital, both administered by a dean and director. A far-reaching weekly clinico-pathological conference was instituted many years ago and has continued to function. Practically all patients who die in the large hospital go directly and promptly to the department of pathology *and the complete sealed clinical* record goes with the body. Autopsy is carefully done and tissues and cultures promptly worked up. The findings and such specimens as are significant are preserved until the next weekly meeting of the clinico-pathological conference.

At the conference a brief clinical report is made, followed by the report, with demonstration of specimens by the pathologist. The results are always interesting, often stimulating, and sometimes depressing. All physicians are invited to attend these conferences and many accept. All medical students, interns and house officers are required to attend, and many members of the faculty are always present. It was from material handled in this way for years that the Sisons were able to compile their report.

Of the more than 10,000 complete clinical and post-mortem records available, the authors selected only the medical cases. As has long been the custom in that splendid service, each *diagnosis* is entered. The average patient having from two to ten clinical diagnoses just as they have several anatomical diagnoses. In Sison's medical cases, there were 2282 clinical diagnoses and 3046 anatomical diagnoses in the same bodies.

THE FINDINGS

In the series of 3260 diagnoses there were 526 errors of commission; in the clinical diagnoses, 848 errors of omission; 1886 correct diagnoses.

Divided somewhat by systems, the percentages of error were as follows: Errors of commission, 16 per cent; errors of omission, 25 per cent; correct diagnosis, 58 per cent.

Further appreciation of the value of this work is made by including comparable figures from Cabot's report of the Massachusetts General Hospital cases some fourteen years ago along the same lines:

	Massachusetts General Hospital Per cent	Philippine General Hospital Per cent
Circulatory diseases	34	35
Respiratory diseases	45	38
Urinary system	53.3	54
Digestive system	43.6	36
Nervous system	31	58
Miscellaneous	6.5	33

The striking differences in the findings in the two series under headings of "miscellaneous" and "nervous system" are explained in the article. The reasons are not of a kind that reflect unfavorably upon anyone's work.

THE WORK OF THE ROCKEFELLER FOUNDATION

The annual report of the Rockefeller Foundation sketches such an amazing volume and variety of activities that a reviewer can note only a few of them. Few people realize the far-reaching and rapidly growing influence of this immensely wealthy foundation, nor the ramifications it is making into many phases of the social and health structure of civilization. Few will question the motives of the trustees of this vast private fortune, and all will applaud most of the things they are doing.

Some have, more do, and many will in future hesitate to endorse *all* of their *methods* and may even question the judgment of the trustees in certain particulars. This, of course, is unavoidable in any enterprise, and it is particularly true of those who serve the human race in the broad fields of health.

Physicians will be interested in the apparent effort of the Foundation to split the profession of medicine into two professions: "The idea that an ordinary medical education fits a doctor to be a health officer is a serious error which does much harm. He needs additional graduate training for what is recognized as a special profession," says President Vincent in his annual report.

The report outlines as among the "most important and fundamental duties" of a county "Health Officer"—"demonstrations in sanitation, the provision of a pure supply of water and milk, medical inspection of school children, organization of *maternity and infant welfare centers,* and the creation of centers for suitable care of such diseases as tuberculosis, trachoma, the venereal trio, and for the correction of remediable defects in children . . . and he will have to study his field so as to be prepared to give advice to the INDIVIDUAL." "There were, at the end of the year 1923," says President Vincent, "230 counties in twenty-eight states of the United States with full-time health organizations. The number grows each year, and a few counties which have given the system a *trial fail to continue it* and to expand the unit to meet the more obvious needs of the people."

When each of the some three thousand counties of the United States has a well-paid, full-time "Health Officer" who is even an educated licensed Doctor of Medicine we will have made the most important step in public health now confronting our people. When each of these full-time public health physicians has added to his staff sufficient nurses and administration force, another long step will have been taken which none now living is likely to live long enough to see accomplished.

During the development of these plans, we hope to see the schools of public health turn out more specialists who will have the ability and the tact to become leaders in our many great centers.

When the people have been educated to appreciate and *finance* even these expensive movements, it will be time enough to say that "the day is passed when any physician qualified for practice can act as health officer."

With full appreciation of the vast, wonderful and

praiseworthy work the Rockefeller Foundation is doing so well in so many ways and admitting the fine motives that we are ready to believe activate the trustees of the Foundation, many physicians and other persons nevertheless feel that they are delaying the consummation of some things much to be desired by methods that are at least immature.

WHAT'S THE MATTER WITH THE COUNTY SOCIETY?

Now and again—with increasing frequency of late—there comes notification of the organization of an independent medical society, a physicians' "club," or of the creation of some sort of association of physicians already members of a county medical society. The announcement of one of these, recently organized, stated: "The idea primarily guiding the establishment of such an organization is one which aims at developing greater social intercommunication and better human relationship among members of the profession." What's the matter with the county medical society in that bailiwick?

Another independent organization announced its birth into this overorganized world with a statement to the effect that it was intended to bring about a better understanding among members of the profession and its community, with respect to their social and professional privileges and obligations, and to create firmer friendships and more constant and effective general co-operation between its members; but more particularly to give better opportunity for them to help each other to become better qualified as practicing physicians. What's the matter with the county society in that bailiwick?

What is it that these purely local medical groups can do that the county society cannot do? Just what is the matter with the county society within whose jurisdiction independent organization is being effected by its own members? It may be that a careful investigation into the situation by its officers will discover something wrong and that a little careful study will result in correction, to the end that the need for new non-affiliated organizations will quickly disappear. Incidentally, the district council might help some. —American Medical Association Bulletin.

"IN TWENTY-EIGHT CASES THE PATIENTS WERE—"

I have just completed the editorial examination of three articles submitted for publication in CALIFORNIA AND WESTERN MEDICINE. Improper and even stupid use of "case" or "cases" was corrected in over fifty places in the some 12,000 words contained in the three articles.

Instances like the above heading, where the author goes out of his way and adds useless words to his article apparently solely in order that he may use his beloved word "case" are extremely common in many, many manuscripts.

The "treatment of cases"; the "death of cases"; the "improvement of cases"; "the early stage of cases"; and scores of similar faulty uses of this word by writers who know better contribute a tedious and trying problem to every medical editor.

"Case" and "cases" are perfectly good words when properly used; but they neither die, get well, nor do many of the other things they are charged with. *"Case" is not synonymous with "patient."*

I do not pretend to be a stickler for excellent English, and believe in granting to everyone the right to use words, as he does methods, as his servants. *But there are limitations beyond which no one should go.*

MEDICAL HISTORY

The May number of CALIFORNIA AND WESTERN MEDICINE will be devoted largely to articles about the history of Medicine—particularly California medicine.

Doctor Hans Barkan, secretary of the Pacific Coast Society for the Study of the History of Medicine and the Natural Sciences, has assumed co-editorial responsibility for the number. Several articles are already in hand, and arrangements have been completed for others. Doctor Barkan, 516 Sutter street, San Francisco, welcomes suggestions, notes or short, carefully prepared articles upon any phase of California medical history, provided they are in his hands before March 1.

We are particularly anxious to have a copy of "A History of the Medical Profession of Southern California," written some years ago by George Kress. Any reader who may have a copy will assist us by loaning it to our office.

A FREQUENT FAULT OF MEDICAL WRITERS

A recent article in a medical journal opens with this statement: "Diet in pregnancy has been given too little attention by the medical profession, and even obstetricians do not, as a rule, scientifically determine the composition of the patient's diet, as to caloric value, and relative carbohydrate, fat, and protein content."

Further on in the article the author says: "As one endeavors to lay out a diet for the pregnant woman, it becomes apparent at once that there can be no routine diet for pregnancy. Intelligent management demands that each patient receive special attention. For some patients there need be no modification from the usual diet, while for others very rigid restrictions must be made."

It is often stated that one of the reasons for writing a medical article is to bring the author's conclusions, and incidentally the author, to the attention of his colleagues. *Why then open an article, as so many do, with a criticism of doctors and thus invite the reader's resentment as many writers do?* The above quotation is chosen because the criticism is exceedingly mild compared with that in copy as most editors first see it.

One of the most difficult and inexcusable problems every medical editor has to solve is to delete from medical manuscripts, or render innocuous, criticisms of physicians, usually unwarranted.

WE WISH TO MAKE A PLEA TO OUR AUTHORS TO SAVE THE EDITOR TIRESOME WORK AND ENHANCE THE VALUE OF YOUR CONTRIBUTIONS BY OMITTING CRITICISM OF FELLOW PHYSICIANS FROM SCIENTIFIC ARTICLES. IF AN AUTHOR WISHES TO CRITICIZE AND WILL DO SO IN A SEPARATE LETTER OR ARTICLE WE WILL PUBLISH IT IF IT IS NOT LIBELOUS.

Medicine in the Public Press

"Mental Menopause"—This new slogan invented by a "psychologist" is being used as the latest fad in defending criminals.

It is said that an alleged murderer is suffering severely from this "Alzheimer's disease" or "mental menopause," and that his attorneys are putting it forward as the reason for acquittal and as the explanation for the philandering propensities that led up to the murder.

Quite a catchy slogan. If the law recognizes the disease (?) we may look forward to another new line of clinics.

To License Child-bearing—Hornell Hart, Professor of Social Economy at Bryn Mawr College, Pennsylvania, is quoted as saying that: "Chauffeurs are licensed, a plumber is not allowed to meddle with your house-drain unless he is licensed, and a doctor cannot prescribe for your children's ills unless he has spent years in study and received a license. And yet so vital a matter as the bringing of children into the world is practically without regulation or legal restraint."

The time has now come, Professor Hart insists, to apply intelligence rather than sentiment, and go one step further and *require every married couple to get a license before they bring a child into the world.*

Hart foresees the day when each marriage license bureau will have on file an up-to-date list of the mentally deficient, just as the police departments have records of criminals.

The Marriage License Bureau is about the only government agency left that does not find some excuse for conducting a "clinic." This will provide them with the excuse.

It will be a "busy clinic," and we presume a "free" one. Think of all the jobs for "doctors" who must carefully "survey" both the man and woman before marriage. Then when they decide after marriage that they want children, they must get another license from another department of the clinic before making efforts to bring one into the world.

What about the bootleggers in child-making? There are plenty of them in this field now, and their "goods" appear quite serviceable, even though they are citizens under disguised labels.

Therapeutic Thaumaturgy—Under this title, Arthur J. Cramp of the American Medical Association Council on Pharmacy and Chemistry tells a story (American Mercury) about medical frauds that every doctor will appreciate.

Freeing Mankind From Disease—Under this title, Doctor W. W. Keen, the most universally beloved and most widely honored of living physicians, tells (Collier's) what he calls the "amazing story" of modern accomplishments in the world's campaign for better health. Every physician and other health worker, as well as other intelligent citizens, should read this stimulating, encouraging, helpful message. It is told in the simple, clear, convincing style that ever characterizes the worthwhile message.

Is This a Just Criticism?—A professor in a public health school which invites physicians as students, in discussing certain phases of parasitism (Scientific Monthly), makes this unnecessary and uncalled for criticism of physicians: "The physician, usually knowing nothing of parasites except the symptoms which some of them produce in human beings, is, of course, prone to believe that the injury of the host is an essential property of a parasite, and to declare that even when we can see no injury one must nevertheless be present."

Another "New Cure" for Cancer and Baldness—Several newspapers published a story sent out from the Radiological Society of North America, meeting in Kansas City, to the effect that the ultraviolet ray would "cure" baldness and cancer!!

The essayist is quoted as having said that the ultraviolet ray "would grow a fine outfit of hair on a head as bald as a billiard ball." And what it wouldn't do to cancer—Oh boy!

The story had such a familiar ring that most editors refused to run it or sent it to the advertising department for consideration as paid space. One paper published part of the story as the doings of the Radio Logical Society. That editor has a sense of humor.

A Prophet and His Own Country—News dispatches announce the arrival in New York of a French doctor with a new "sure cure" for pneumonia. The "doctor" is quoted as saying that "Pneumonia is really not dangerous at all." "And certainly there is no reason for its ever being fatal." "Even persons in the last stages can be cured, as if they had nothing more than a bad cold."

Some editors evidently sent this propaganda to their advertising departments, and others published it as "news"! Any doctor who had a cure of the kind described would not have to leave Paris and come to the United States for patients.

If Benjamin Franklin Came Back Today—"Benjamin Franklin died in 1790—134 years ago. Could he return to make appraisal, what wonders would confront his astonished vision, what triumphs of the Fifth Estate compel his admiration!" says Arthur D. Little (Atlantic Monthly). "The Fifth Estate being designated as 'composed of those having the simplicity to wonder, the ability to question, the power to generalize, the capacity to apply.'

"In great hospitals, permeated with the scientific spirit and equipped with many new and strange devices for the alleviation of human suffering, he would hear of the incalculable benefits which medical and surgical science have conferred upon mankind. He would see the portraits and listen to the story of Pasteur and Lister and Loeb and Ehrlich. We know today with what joy and relief the world would welcome a veritable cure for cancer, but we can little realize the emotion with which one like Franklin would learn in a single afternoon of the germ theory of disease, of preventive serums, of antisepsis, of chemotherapy, of the marvelous complexity of the blood stream and the extraordinary influence and potency of the secretions of the ductless glands. What appraisal would he make of the service to humanity which, in little more than a generation, has mitigated the horrors of surgery by the blessings of anesthesia and antisepsis, which has controlled rabies, yellow fever, typhoid fever, tetanus, which is stamping out tuberculosis, curing leprosy, and providing specifics for other scourges of the race? What values would he put on insulin, thyroxin, adrenalin? The physician is no longer compelled to rely on herbs and simples and drastic mineral compounds of doubtful value and uncertain action. Compounds of extraordinary potency, isolated or synthesized by the chemist, are now available to allay pain, correct disorders, prolong life, and even to restore mentality and character."

Shall We Have Health?—Under this title, a San Francisco newspaper is conducting what it pleases to term a "New Kind of Health Column." It is. It is essentially a criticism of "orthodox medicine," calculated to undermine the confidence of the sick in the ministration of healing, consolation and mercy, as carried out by their physicians. The author of the column wishes to bring back into "full play the only remedial agent known to true science—The Healing Force of Nature—the vis medicatrix naturae of the ancients."

We wonder what killed people and killed them at much earlier ages than now in those good old days of "vis medicatrix."

Where the Highest Skill is Needed—The medical service required in making periodic health examinations is of a high order, in that it requires not only time, but also discriminating judgment rightly to interpret the significance of various minor findings in relation to habits of living.—Anna Richardson (Medical Times).

California Medical Association

MEMBERSHIP DUES

The membership assessment of the California Medical Association and of your County Society is now due and payable. Delinquency is as of March 1. Non-payment after that date debars a member from participation in the state program, from holding office, and from the receipt of CALIFORNIA AND WESTERN MEDICINE until reinstatement. Many members carelessly let their membership lapse and, upon reinstatement, write for the omitted numbers of CALIFORNIA AND WESTERN MEDICINE. In very few instances has the secretary's office been able to comply with such request.

The California Medical Association dues for 1925 were fixed at $10. The prompt payment of this sum, together with your county assessment will obviate later grief.

1925 SESSION C. M. A.

Reservations—Reservations for the 1925 session will be handled by the Yosemite National Park Company direct, and will be opened as of March 1. For the information of those who have not attended a Yosemite meeting, Yosemite Lodge will be convention headquarters.

Various kinds of accommodations are available. Rooms in the Sentinel Hotel and also detached redwood cottages with bath, both in conjunction with meals in the main dining-room, can be had on the American plan at the rate of $8.50 per day. Redwood cabins and rooms in the Sentinel Hotel without bath, and with meals in the main dining-room are furnished at $6 per day. Canvas cabins without bath are $2 per day. Meals in the cafeteria average about $2 a day. It is obvious that the cost of attendance on the convention may range between $4 and $8.50 per day.

When a reservation is made with the Yosemite National Park Company, the applicant is sent a questionnaire, asking for definite instruction as to the kind and cost of room desired, the duration of his stay, the date of arrival and the number in his party, and the route by which he expects to reach the valley.

This office would appreciate a full and prompt reply to this questionnaire, as from it our registration cards will be made out. Each member will be indexed by his county and name before his arrival, and the tiresome and annoying delays incident to the usual registration obviated. The registration desk will be at the extreme left-hand of the main porch of Yosemite Lodge. Every member should report there immediately on arrival. The number of his assigned room and his ticket to the dining-room or cafeteria will be furnished him at that desk. His luggage is in the baggage room immediately adjoining the registration desk, and boys will be on hand to show him to his assigned quarters.

Program—Section officers report active progress on the meeting program. On February 15, the program closes. All members who desire to present papers should secure a place on the program before that date.

THEODORE RETHERS
1867-1924

The death of Doctor Theodore Rethers recently is a distinct loss to the medical profession of San Francisco and California. His passing is a greater loss to his many friends and patients whom he served so skilfully during his lifetime.

Doctor Rethers was a man of exceptional scientific and mental attainments which, combined with his great simplicity and sympathetic friendship, made him a most human doctor and loyal friend. His skill as a surgeon is known to the physicians, and needs no added tribute at this time.

The funeral was a notable outpouring of all classes of people, and the eulogy pronounced by his lifelong friend, Monsignor Joseph Gleason of Palo Alto, was one of the most eloquent tributes ever heard by the friends of Doctor Rethers and the professional men who attended the obsequies.

Doctor Rethers was born in San Francisco June 28, 1867. After attending the public schools he went to the University of California, leaving there in 1885 to study medicine in Germany. He obtained his degree magna cum laude in the University of Berlin.

Returning to San Francisco in 1892, he began the practice of his profession. In the following year he was appointed a member of the San Francisco Insanity Commission, a position which he retained for thirty-one years.

In 1898 he went with the First California Volunteers

as regimental surgeon to the Philippines, remaining with the Army until the end of the Spanish War. Later on, during the administration of Governor Johnson, he was appointed surgeon-general of the National Guard of California.

For the past fifteen years, Doctor Rethers was surgeon-in-chief of St. Mary's Hospital of San Francisco. It is said of Doctor Rethers by Doctor John Gallwey and others that, more than any other doctor and surgeon, Rethers gave assistance, advice and professional help to the younger members of the profession.

In 1896 the Doctor married Annie O'Kane, the daughter of a pioneer San Franciscan. He is survived by his widow and six sons—Theodore, Frank, Harry, Edward, Charles and Robert, and a brother, Colonel H. F. Rethers, U. S. A.

EULOGY PRONOUNCED AT THE FUNERAL SERVICES BY MONSIGNOR JOSEPH GLEASON

"We are assembled to do honor to the memory of Dr. Theodore Rethers, a public-spirited citizen, a true friend, a devoted father of his family, a veteran surgeon of the Spanish-American War, a recognized leader of the medical profession in California. His life was an inspiration to us all. It was my privilege to know Dr. Rethers from childhood. From his earliest days he had the faculty of making friends and holding them. He never from his youth took up a problem that he would not see through to the finish, and this characteristic of work and thoroughness characterized his entire career. He was noted for this during his university course and his professional studies in Europe. When, therefore, after his return to California, he began his career as a young doctor, it took but a very short time for him to obtain recognition. By unremitting study he kept abreast of scientific advances and he was accorded a position of leadership, particularly from the members of his own profession.

"He was a man, however, who had not merely the technical knowledge and skill of the accomplished physician and surgeon, but he had with it that Christian character which always ennobles the physician. I never met a man who had a higher regard, not for the mere dignity, but for the actual sanctity of his profession. There are two great mysteries of human life, our entrance into and our exit from the world. At these the physician presides. He welcomes the new born babe, he bids Godspeed to the dying. It is a very easy thing for a physician to become so familiar with the technique of his profession in handling the human body to forget that that human body is the temple of God. The physician and surgeon who forgets this, and callously ignores the divine mystery of life, is very liable to become little more than a cold blooded mechanic or an artistic carver. The real inspiration of the physician and surgeon's professional life is the recognition of the fact that he is handling the work of God. Dr. Rethers never allowed his skill as a surgeon or his long practice in his profession to breed that familiarity which fathers contempt. And the reason of it was that Dr. Rethers was a man of faith—he believed in God—and that faith guarded him and guided him. This may explain to a certain extent the remarkable trust that his patients always had in him. He was their friend. Rich or poor, black or white, there was no distinction, every man who ever was his patient remained his friend. He was devotion itself in his attendance. The relation between the physician and his patient is very parallel to the relation between the priest and the penitent who comes to confession. Both priest and physician are custodians of the secrets of the soul. They must have the faculty of inspiring confidence and they become confidants whose sacred trust can never be broken. On this account the role of physician was to Theodore Rethers almost sacramental in its sanctity.

The physician and surgeon are supposed to lead a life of self-sacrifice. He actually did live that life of self-sacrifice. There was no doctor who more heartily abhorred the necessity of a monetary compensation for his services. From my own personal knowledge he had a large clientele from whom he could never receive any returns.

Dr. Rethers was endowed with the sense of humor. There is no question but that this is a real gift from God. The man who can laugh will find it a very easy matter to save his soul. There was a merry twinkle in the eye of Dr. Rethers that spoke the joy of his soul and kept his friends in good humor. It was a tonic to his patients. It served to bridge him over two or three severe crises in his own life for it was not all smooth sailing in the long years of his professional career and when difficulties did come, his faith in God and his sense of humor saved the day for him.

"Privileged as I am today in speaking over Dr. Rethers, I am prompted to recall a little incident in the life of St. Paul that the ordinary reader might gloss over. St. Paul, convicted in Syria, appealed to the Supreme Court of the Roman Empire. When the time came he was shipped on a Roman transport and sent on to the Capital. Under the Roman law even an officer's wife could not go with him on the transport. There was only one allowed to accompany a prisoner and that was his personal slave. St. Luke, who wrote the third Gospel and who was the companion of St. Paul in his missionary journeys, was likewise a physician. He was devoted to St. Paul and when the Apostle was shipped on the transport, St. Luke, the physician, took advantage of the one loophole in the Roman law and signed up as the slave of St. Paul. It always comes before me as an example, not merely of personal fidelity, but of the devotion of the physician. That same St. Paul, when he wrote from his prison in Rome to his friends in Greece and Asia Minor, spoke of all his companions leaving him, one after the other. How human it is to read that little line of his where he says, 'they have all left me, all except Luke, my beloved physician.' This warm relationship between physician and patient was always the characteristic of Dr. Theodore Rethers.

"From childhood I knew him in the thoroughness of his study, and in the integrity of his character. It was my privilege years ago to officiate at the ceremony which united him and his bride. I have seen him develop, with the highest recognition in his profession, and I always found him the same—quiet, unassuming, good-humored, devoted and self-sacrificing. He lived and died a credit to the medical brotherhood of California. All of them will miss him, but he will be held in particularly grateful remembrance by the army of young physicians whom he guided and helped in the first difficult steps of their career. He was the friend of all, but especially of the young doctor.

"Gathered in this sacred edifice, please do not forget that Dr. Rethers was a sincere Christian believer. He understood and appreciated the Catholic philosophy of life and death. He would remind you, if he could speak from his casket today that we have come here not to honor him with empty words. He has finished his term of probation here in this world and the good God has beckoned him through the gate of death. At this solemn Sacrifice of the Mass, the holiest act of the Catholic religion, we are assembled for a nobler purpose and that is to say a prayer for the repose of his soul. Common ordinary decency develops charity in the heart of man. Like all decent men you feel that a man who will not reach out a sympathetic helping hand to one in distress is beneath contempt. And because we believe in giving a helping hand to the living, it is very easy to understand the Catholic practice of extending our charity beyond the grave and saying a prayer for the repose of the dead who can no longer help themselves. That is why we are here today. If it were simply a matter of doing civic honor to the memory of Theodore Rethers, a few words and a quartet in a public hall would cover the program. On the contrary, all of us are assembled today as friends of the dead doctor for the specific purpose of doing for him, what he, as a Christian believer, would do for you if one of you lay in that casket today. No matter what might be your religious belief, he would give you the best that his Catholic religion afforded him under the circumstances, namely, a prayer for the repose of your soul. That is what I ask of you now. Unite with me in saying within your hearts these words: 'Forgive him, Oh Lord, for any mistakes he may have made. He was human but he was thy faithful servant. Remember his good deeds and blot out the chance error. Eternal rest grant unto him, Oh Lord, and let perpetual light shine upon him.'"

LUTHER MILTON POWERS, M. D.
1853-1924

Doctor Luther Milton Powers, for thirty-two years Health Commissioner of Los Angeles, died October 31, 1924.

He was born in New Hanover County, N. C., April 5, 1853, attended Wake Forest College, North Carolina, and was graduated from Washington University School of Medicine in 1877. After post-graduate study at Bellevue and the College of Physicians and Surgeons of New York, he practiced medicine at Plymouth, N. C., until 1886. Then, after a year in Nebraska, he came to Los Angeles. Doctor Powers is survived by his widow, Mary R. Powers, two daughters, Mrs. Anne Powers Keller, Miss Lucy Powers, a son, William, and a grandson, Milton Powers Keller.

When the history of the last three decades of Los Angeles is written by impartial observers, the work of Luther M. Powers will be so outstanding that he may be easily awarded the honor of being our most useful citizen. In the delirium of his last hour he called upon those about him to save the children from diphtheria, showing that the "ruling passion is strong in death."

WILLIAM DUFFIELD.

Los Angeles County Medical Association Honors Doctor Powers' Memory—WHEREAS, The death of Doctor Luther Milton Powers, Health Commissioner of Los Angeles for almost a third of a century, should cause, and does cause, this society and our profession to pause and meditate upon the work of a most useful citizen and physician, and to honor his work and the good name he has left among us.

The study of the life of Doctor Powers is a study of the evolution of modern scientific sanitary medicine, for his connection with the Los Angeles Health Department goes back to the time when that which is now considered basic in public health work was in its beginning. Through study, travel, and association with leaders in the thought of the time, he became an authority in sanitation and public health. He built our health department from a service of two men to a great department with sixteen divisions employing several hundred men and women in its various activities.

He was in advance of his day in organizing a bacteriological service, and he was one of the real pioneers in the crusade for pure milk and in the establishment of milk commissions. The remarkable working efficiency of the department was demonstrated just at the time of Dr. Powers' death by the instant recognition of pneumonic plague and its annihilation within ten days of the onset. No more efficient public health service was ever given in a grave emergency at any place.

Dr. Powers was past president of the Los Angeles County Medical Association. He served on the Board of Councillors for many terms, where his service was most valuable, because of his wide acquaintance and good judgment. His whole life and work were in and for organized medicine, and no man ever served the profession and the public more faithfully, more loyally, nor more unselfishly.

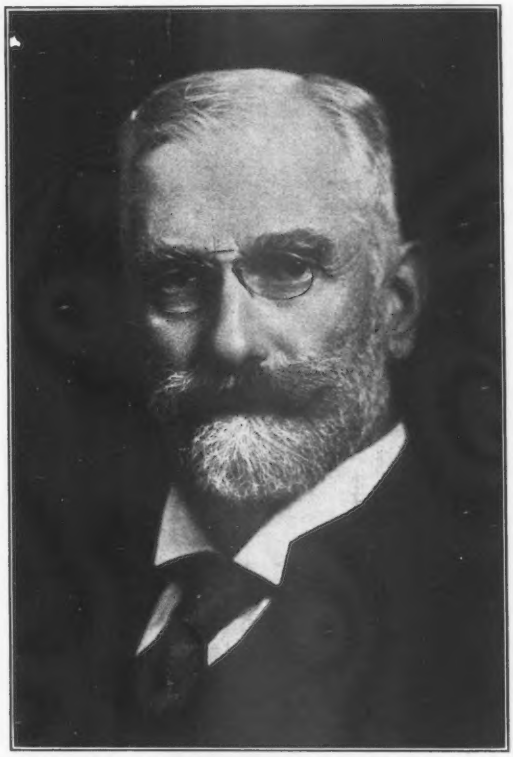
In view of the great service rendered to mankind by Luther Milton Powers, it is hereby

RESOLVED, That a tablet of bronze be placed in a conspicuous place in the County Medical Building, recording the distinction of his service and the high esteem in which his name is held.

RESOLVED, That one scientific program, devoted to public health and sanitation, be given each year in memory of Doctor Luther M. Powers and Doctor Stanley P. Black, two outstanding pioneers in public health medicine.

RESOLVED, That the sympathy of this society, with the expression of our highest esteem, be extended to the bereaved family of Doctor Powers.

F. C. E. MATTISON.
ELMER R. PASCOE.
WILLIAM DUFFIELD.



FRIEDRICH FEHLEISEN, M. D.
1854-1924

(Eulogy by the San Francisco County Medical Society)

In Doctor Friedrich Fehleisen, the San Francisco County Medical Society has lost a member whose name is known wherever medicine is taught. His work will live after him, but so modest and devoid of pretentiousness was he that not many of his younger colleagues knew by name the upright and austere figure that used to sit at the back of the medical meeting room, quietly and attentively, often it seemed, pensively and reminiscently listening. Not many of the younger men to whom he listened knew that this was Fehleisen, the discoverer of the streptococcus of erysipelas. And as he would get up and stride solitarily and silently from the meeting, he

seemed to carry with him the shades of other hours—of V. Bergmann's clinic, of attendance upon emperors; and his mind to muse upon the vagaries of Fate and the determination of life by the whims of kings.

Friedrich Fehleisen was born on the 20th of April, 1854, in Reutlingen, Germany. His father was Doctor Friedrich Fehleisen. He studied at the Universities of Tübingen, Strassburg and Würzburg, and took his degree at Würzburg in 1877, with a dissertation "On a Case of Aphasia." For many years he was V. Bergmann's first assistant and head surgeon of the surgical clinic of the University of Berlin. He left Germany in 1895, taught for a short time at Washington University, but soon followed an invitation of Doctor Vowinckel of the California Women's Hospital to visit him. He remained to make San Francisco his home, and succeeded Doctor John F. Morse as chief surgeon to the German (now the Franklin) Hospital in the same year—1895.

Fehleisen married Fraülein Marie Herdtmann in 1890. He leaves two children. His wife was one of two German nursing sisters chosen by the Empress Frederick to learn English nursing under Florence Nightingale. She returned to V. Bergmann's clinic after a course at St. Thomas' Hospital in London. Finding it difficult to get volunteers for the diphtheria ward, she volunteered for this duty herself, and there first met Fehleisen.

Fehleisen died suddenly on the 28th of August, 1924, of heart disease.

His fame will rest on his discovery of the germ of erysipelas; he also made pioneer research into the influence of streptococcic infection on malignant tumors.

Germany was unfortunate to have lost this man, but we were the gainers. The memory of his person and the influence of his work, which fell at the beginning of the constructive period of San Francisco medicine, remain ours; and ours is the figure of this earnest, modest, and upright surgeon.

OSWALD H. BECKMAN, M. D.
1851-1924

It is with great regret that we note the loss of one of our members, Dr. Oswald H. Beckman, who died at his home in Glendale, November 28.

For fifteen years he followed his vocation in Fort Bragg, Mendocino County, where he owned and managed Beckman's Sanatorium.

As secretary of the County Society, he devoted himself untiringly to its welfare and growth.

Always energetic in his efforts to uphold principle and justice, his loss will be felt in both County and State Society.

JOSEPH WILLIAM JAMES
1876-1924

On Saturday, December 13, 1924, Doctor J. W. James was borne reverently to the grave by members of the profession, by whom he was so highly esteemed and for whose welfare he so valiantly labored.

The twenty years and more of his career as a physician and surgeon were terminated at the height of his usefulness and endeavor, but if estimates of a life are to be measured, not by the number of years lived, but by the amount of good accomplished, then Doctor James furnished an example which few can equal, none surpass. If one is required to give an epitaph adapted to his character and career, "I live to serve" would be most fitting. To him, medicine was truly an art as well as a profession, and his happy buoyant nature, coupled with an unusual sense of duty, enabled him to bring hope and cheer when physical means failed.

Born of sturdy Welsh-English parentage, he came to this country early in life and literally carved his own career. Circumstances compelled him to rely chiefly on himself for support in his education, but his will to succeed readily overcame all obstacles and brought out that determination of character, which, knowing the right, fights to achieve and always wins. Of the great numbers who employed him, there were none but remained his friends, for it was easy to realize that he gave himself wholly and freely to his tasks, no matter how trivial.

That which was finest and best in life guided his every instinct and act, as the loadstone and the star. Art, music, literature and things refining and cultural, always engaged his interest and support. His abundant enthusiasm and energy carried him far and, in good measure, were contagious. Without his support, the splendid Sutter Hospital, recently erected and operating, could hardly have been carried through. In spite of the demands of a large and exacting practice, he saw the new institution

functioning chiefly through his own efforts. His name is indelibly linked with it.

As a citizen, Doctor James more than performed his part: serving faithfully and for many years on the local Board of Health and the State Board of Examiners; in civic matters, he gave freely of his purse and time; all movements seeking better hygiene, social or economic improvements, had his enthusiastic support and undivided attention.

Though he persistently sought to enlist in the late war, impairments caused the authorities to restrict or decline his services. All honor to those who exposed themselves in the front line, but the war could not have been won without the united support of those "behind the lines," and of these Doctor James led in examples of patriotism and successful endeavor.

Life has been likened to a beautiful mosaic, built up of a number of small stones or bits, each one representing a deed well done. The good deeds accomplished by Doctor James have aided, bit by bit, in making of his career the picture of a good life, long to be cherished and revered by his friends and associates. Wise counselor and esteemed friend, he "sought to prove all things and to hold that which was good."

S. E. Simmons, M. D.

ALAMEDA COUNTY

Alameda County Medical Association (reported by Pauline S. Nusbaumer, secretary)—The program at the regular meeting of the Alameda County Medical Association held November 17 was devoted to a symposium on encephalitis lethargica. In his paper, "Epidemic Encephalitis from the Experimental Standpoint," William Lee Bender of San Francisco stated that recent investigations have established the presence of widespread spontaneous encephalitis in rabbits, throwing open to doubt results of previous experiments on the etiology of encephalitis in man. He and his co-workers have been able to immunize rabbits against experimental encephalitis, which offers a means of studying the relation of various strains of virus to each other. He further stated that no uniformly satisfactory treatment of epidemic encephalitis had been developed, that there is no specific therapy, and that it might prove possible to confer immunity to a man as well as to rabbits.

Albert H. Rowe, in his paper, "Clinical Aspects of Lethargic Encephalitis," went into the symptoms and physical findings in detail. The importance of following up cases of encephalitis was emphasized, since sequelae are apt to be accompanied by persistent mental irritation, insomnia, hallucination and, at times, neuritic pains in various parts of the body. In view of the severe sequelae and the progressiveness of the disease in such cases, any reports of successful treatment should be followed up. At this time protein injections, especially in the form of typhoid protein administered under the most careful supervision, seems to be of value. Reports of success with other forms of protein therapy, such as non-specific serum or milk injections, must be kept in mind.

Sydney K. Smith's paper, "Psychiatric Sequelae of Encephalitis Lethargica," included the consideration of the following points: 1. "Lethargic" encephalitis is a misnomer. 2. Encephalitis is a syndrome and not a disease entity. 3. The psychiatric sequelae may include behavior and character changes—adult and juvenile, manic or depressive episodes, emotional apathy and less often trend reactions. 4. Our knowledge of encephalitis is so recent that the ultimate psychiatric prognosis cannot properly be given. 5. Summary of series of seventeen cases.

The discussion of these papers was opened by R. T. Legge.

At the Fabiola Hospital staff meeting, R. L. Richards read a paper on "What We Think With," setting forth the development of the brain according to the different stages of growth.

A. H. Rowe gave a talk on the "Treatment of Asthma," disclosing new discoveries and noting the progress that has been made during the last four or five years.

Upon the retirement of Susan J. Fenton from the Fabiola staff, W. L. Bell said in part: "It is not necessary to say how faithful, honorable, and ethical Dr. Fenton has been during the long years of her service. She has given most generously of her time, her knowledge and her money. This fine gentle woman has been an honor to her profession and to this staff."

At the meeting of the Merrit Hospital staff on December 8, W. H. Barnes reported three fatal cases of infections with pyogenic staphylococci. Emphasis was placed on the importance of early recognition of the infection, absolute rest of patient and the infected part, proper elimination, and intelligent surgical intervention. Intravenous injections of gentian violet and mercurochrome failed to stop the advance of the infection in these cases.

A. C. Siefert spoke of his attendance at the annual meeting of the American Roentgen Ray Society at Swampscott, Mass., and his visits to the leading hospitals, both in the United States and Canada. The doctor saw much of interest, and found that each group of men had some special work in which they particularly excelled.

FRESNO COUNTY

Fresno County Medical Society (reported by T. Floyd Bell, secretary)—A special meeting of the Fresno County Medical Society was held at the Hotel Fresno at luncheon on November 15.

Those present were: Aller, Bell, Couey, Cowan, Cross, Ellsworth, Goldberg, Jamgotchian, James, Kjaerbye, G. L. Long, Luckie, Madden, Manson, Mathewson, Miller, Montgomery, Morgan, McPheeters, Pettis, Schottstaedt, Sciaroni, Staniford, Stein, Thompson, Tillman, Tobin, Tupper, Vanderburg, Wahrhaftig, J. R. Walker, G. W. Walker, and Willson.

Gavin J. Telfer, district health officer of the California State Board of Health, discussed plague. He went into the history of plague in the old world, and also in California, and said that the disease was endemic among animals all over California. The first case was discovered in this state in 1900, and there have been several outbreaks since. The squirrels in the region of San Francisco harbor the infection and transmit it to humans. In July, 1924, it was noted that the rats and squirrels in the region of San Luis Obispo were dying rapidly, and investigation showed that 20 per cent were infected with bacillus pestis. More recently there has developed an outbreak in Los Angeles, with the pneumonic form prevailing. He spoke briefly of the symptoms of both the pneumonic and bubonic types. The mortality is very high, being 90 per cent to 100 per cent, with the pneumonic form. Those who do recover do so after about ten days, but the convalescence is long and drawn out. The organism is easily stained and cultures are definite. Animal inoculation is the positive test.

Prevention of plague is the important means of attack on the disease. Attendants must be protected by mask and goggles, as well as the other ordinary means of protection. Vaccination and serum has no relation to the control of the disease. The main means of prevention is eradication of the rodents. The measures that should be used in Fresno are those used to eradicate the rodents. There should be no squirrels within ten miles of the city and a minimum of rats in the city. Make the city as ratproof as possible; sanitary inspection and rat-killing by experienced men.

Cross moved, Luckie seconded, that the secretary be instructed to secure literature on plague for the library. Carried.

The regular meeting of the Fresno County Medical Society was held December 2 at the Hotel Fresno with dinner, this being a social meeting.

Members: Aller, Anderson, Barret, Bell, Broemser, Collins, Cross, Craycroft, Callaway, Dearborn, Goldberg, James, Jorgensen, Kjaerbye, Konigmacher, Lamkin, Luckie, Madden, Manson, Mathewson, Miller, Montgomery, Mitchell, Morgan, Milholland, Pasley, Pettis, Pomeroy, Quimby, Schottstaedt, Sciaroni, Tillman, Tobin, Tupper, G. W. Walker, and Wilson.

Visitors: Dahlgren, Nider, Dow, and Mr. Ben Harrell.

Before being seated, Madden gave the following reading, in memory of the late A. B. McConnell.

"The shadows deepen and we set our faces toward the new year which time will soon usher in.

"The fading of the present year recalls to our minds the brother who answered the silent roll-call, and we pause.

"Let us turn to memory's storehouse and draw therefrom those fine fragments of recollection, the mere thought of which will supplant sorrow with joy.

"Let this be the occasion of a careful inventory of the past of the living, as well as a resumé of achievements of our dead in his earthly struggles, remembering always that the most endearing memorial we can erect will be a constant effort on our part to perpetuate by our faithful devotion to the principals of our profession those things that were dear to our departed brother.

"May he rest in peace."

The application for membership of O. P. Pisor of Monmouth was read.

The following officers were elected for next year: President, A. E. Anderson; first vice-president, W. G. Milholland; second vice-president, Charles A. James; secretary, T. Floyd Bell; assistant secretary, J. A. Montgomery; delegates, T. F. Madden, H. J. Craycroft; alternates, B. Lamkin, R. B. Tupper; board of governors, W. P. Miller.

Doctor Konigmacher had arranged a very pleasing and entertaining musical program, which was presented.

W. W. Cross gave an illustrated lantern lecture on the "Sierra Nevada Mountains." He was raised in the shadow of these mountains and has spent a great deal of time studying them and enjoying their wonders. He told how mountains in general were formed and how the Sierras came into existence and how the ocean washed

their western shores. He then showed pictures of many interesting and beautiful places in this rugged range of mountains.

KERN COUNTY

Kern County Medical Society (reported by William H. Moore, secretary)—The regular meeting of the Kern County Medical Society was held at the Kern County General Hospital November 20, 1924, P. J. Cuneo presiding. Twelve members of the society were present.

L. W. Blake, a new physician in Bakersfield, was present, and R. M. Jones' transfer of membership from Fresno to the Kern County Medical Society was accepted.

Clain F. Gelston of San Francisco read a paper on "Bronchiectasis in Children."

MERCED COUNTY

Merced County Medical Society (reported by Brett Davis, secretary)—The meeting held November 7 was without program, as Dr. Samuel W. Hurwitz, who was scheduled to appear, was unable on account of sickness to be present. December 4, the regular December meeting was held at Merced. Dr. Lee S. Seward of Ahwahnee T. B. Sanitarium and Dr. Charles L. Ianne of Arroyo Grande Sanitorium were present as visitors. These two doctors held a chest clinic the following day in Merced.

Election of officers for 1925 resulted as follows: President, A. S. Parker, Merced; vice-president, T. R. Trick, Dos Palos; secretary-treasurer, Brett Davis, Merced; delegate, W. C. Cotton, Atwater; alternate, C. H. Church, Yosemite.

C. F. Harrar, M. D., who has been in Merced for the past year, has just moved to Turlock, Calif.

While there has been no smallpox in Merced County, public clinics were held by the State Board of Health and county health officer, with about five thousand vaccinations.

ORANGE COUNTY

Orange County Medical Association (reported by D. R. Ball, secretary)—A very excellent paper was provided for the December meeting by Dr. F. E. Coulter of Santa Ana on "Observations on Functional Nervous Disease." The conditions of neurasthenia, psychasthenia, and hysteria were gone into particularly after a broad survey of the field had been given. A plea was made for the proper recognition and treatment of these conditions by the general practitioner.

Officers for the coming year were elected as follows: President, H. D. Newkirk; vice-president, Bessie S. Martell; secretary-treasurer, D. R. Ball; librarian, C. D. Ball; delegate, Harry E. Zaiser; alternate, R. A. Cushman; councillors, John Wehrly, F. E. Coulter, and G. M. Tralle.

The Santa Ana Clinical Society held its regular meeting at the office of the president, John Wehrly, on November 19. A. E. Belt of Los Angeles presented a very interesting lantern slide demonstration of "The Anatomy of the Kidney." The slides illustrated the work which the author did in conjunction with Frank Hinman of San Francisco in winning the gold medal awarded by the A. M. A. in 1921 for the best piece of scientific research of the year. Following this demonstration, Dr. Belt showed an interesting collection of x-ray pictures of various urological conditions.

The profession has, within the last month, lost two of its oldest members in the county. Dr. Willella Howe Waffle, age 70, of Santa Ana died on November 12 while attending a patient. She had practiced in this community since her graduation in 1886. She followed the Homeopathic school of practice. Dr. John L. Dryer, age 79, of Santa Ana died on November 30, after a two weeks' illness. He had practiced in the state since 1877, and in Santa Ana since 1888. He was a charter member of the Orange County Medical Association, and maintained his active membership until his death. Although in poor health for the last few years of his life, he kept up his work in his chosen field of tuberculosis until the last. The profession and the community have indeed lost two worthy and respected members.

Two new names have been added to the membership list: George A. Paige of Anaheim was elected at the October meeting; W. A. Kistinger of Santa Ana, transferring from Livingston County, Ill., was elected at the December meeting.

PLACER COUNTY

Placer County Medical Society (reported by Robert A. Peers, secretary)—The society held its annual meeting in Auburn, Saturday evening, December 6. This being the regular meeting for the election of officers, no literary program was presented.

The following officers and delegates were elected to serve for 1925: President, H. N. Miner, Blue Canyon; vice-president, J. A. Russell, Auburn; secretary-treasurer, Robert A. Peers, Colfax; associate secretary, Charles J. Durand, Colfax; delegate to State Society, F. E. McCullough, Lincoln; alternate, H. M. Kanner, Colfax.

It was decided to have the next literary program in Auburn late in January or early in February.

RIVERSIDE COUNTY

Riverside County Medical Society (reported by T. A. Carl, secretary)—At the annual meeting of the Riverside County Medical Society, officers for the year 1925 were elected as follows: C. R. Geith, president; W. B. Wells, vice-president; T. A. Card, secretary-treasurer.

SACRAMENTO COUNTY

Sacramento Society for Medical Improvement (reported by G. J. Hall, secretary)—At the November meeting forty-four members were present.

Presentation of Cases—Brendel reported a case of rupture of biceps tendon repaired; dislocated semi-lunar cartilage; lengthened quadriceps tendon. O'Brien reported a case of rupture of uterus at six months' pregnancy.

William J. Kerr of San Francisco discussed "Modern Methods of Treatment of Heart Disease." The essayist stated that the most important thing in treatment of cardiac disease is treatment of congestive cardiac failure—muscle failure—signs and symptoms. The principles of treatment are:

Rest most important in treatment of cardiac insufficiency—bed position. Diet: Easily digestible; no effort in mastication; no large amount; frequent feedings, concentrated food. Sleep is necessary—maybe morphine in certain types.

Depletion—Removal of fluid; may use magnesium sulphate; purgation; diuretics. Removal of fluids from body cavities; cupping; venesection 500 to 750 cc. of blood. Bandages in oedema of legs.

Stimulation — First, digitalis; second, caffeine. Diet: avoid gas-forming foods, large amounts of bread, etc. Mode of life to lead afterward. Right kind of work. Graded exercises to develop proper hypertrophy of heart. Prophylactic treatment, removing foci of infections. Digitalis most valuable—sometimes abused—no special indication in rapid heart. Heart failure; then digitalis. Many books state ten drops of digitalis is proper dose—variation in droppers and in tinctures themselves—use graduated dropper or graduate, or place in vehicle. Fifty drops from dropper equals 1 cc. in graduate. Superior to the use of dried or in pill forms. Few contra-indications for digitalis. Quinidine: Chief value in auricular fibrillation is to restore normal rhythm. If muscle failure with edema and anasarea, then digitalis first; later quinidine. May give six grains t. i. d. for three or four days, if first three grain doses are okey. If embolism or heart muscle extensively damaged, then quinidine is no use. Camphorated oil of no great value. Strychnine, long continued use as stimulant in vasomotor system. Whisky aromatic ammonia temporary.

Bacterial rheumatic endocarditis demands attention. Prognosis bad in 100 per cent. Usually young people with rheumatism; no results with any treatment. Saw none recover. Moffitt saw one recover.

For pulmonary edema: Prop up in bed; morphine and adrenalin. If blood pressure is high and cyanotic, should be bled. Take one pint or two pints. Long rest. Angina pectoris and coronary disease: Nitrates or nitroglycerin and rest; if syphilitic, iodides and arsphenamine. More

recently, operations on sympathetic nerves. Pain relieved. Danger of patient overdoing later because the pain is relieved. Luetic aortitis: Differentiate between patients with aneurysm and without aneurysm; if with aneurysm, do not give arsphenamine; if without aneurysm, give tremendous doses of iodides. Patients may die from arsenical treatment. Hypertension: We have probably gone a little too far in trying to reduce blood pressure to certain levels. Heart block: Atropine. Heart in pregnancy: Very few conditions demand intervention. Very few cases of heart disease that contra-indicate necessary surgical operation.

Discussion by Grazier, Gundrum, Reardan, Scatena, O'Brien, Twitchell, Brendel, Drysdale. Closed by Kerr.

Parkinshon talked on the new directory of the C. M. A.

SAN BERNARDINO COUNTY

San Bernardino County Medical Society (reported by E. J. Eytinge, secretary)—A meeting was held December 2 at the San Bernardino County Hospital. Fifty members present, thirty-five absent; fifty guests.

The program: "Allergy," by George Piness, Los Angeles.

The talk was illustrated and accompanied by practical demonstrations, both human and animal.

The following men have been elected to membership: H. Garcelon, Victorville; H. A. Bogue, Ontario; A. S. Garnett, San Bernardino; E. H. Hull, San Bernardino; O. H. Von Emon, San Bernardino; J. A. Patterson, San Bernardino; C. G. Newbecker, Rialto.

SAN FRANCISCO COUNTY

Franklin Hospital Staff Meeting (reported by Ewald H. Angerman, secretary)—The monthly staff meeting of the Franklin Hospital was held on Monday, November 24, Dr. J. Wilson Shiels presiding.

The paper of the evening was "The Treatment of Asthma," by Samuel H. Hurwitz, M. D. This interesting topic was exceedingly well presented by Dr. Hurwitz, and discussed by J. Wilson Shiels and C. E. Taylor.

St. Joseph's Hospital Staff Considers Head Fractures—"The Treatment of Head Injuries" was discussed by Howard Naffziger before St. Joseph's Hospital staff of San Francisco on December 10, Dr. A. S. Musante presiding. Charts and sectioned skulls were used to illustrate the discourse. Treatment of depressed fractures and penetrating wounds from picks and axes is uniformly that of relieving the depressed skull and in opening up, cleaning and draining. Operations during shock should be avoided, as life-saving measures can seldom be withstood. After reaction, x-ray pictures and operation with local anesthesia are in order. Fissured fractures need no operation usually. If the base is fissured, we may have bleeding into the nose, ear or mouth. Meningitis supervenes in about 6 per cent of these, as well as all other compound fractures. Dorsal decubitus and ice cap are recommended.

The brain injury needs attention. Intracranial pressure is important. Acute intracranial pressure generally produces slow pulse, which, when below 50, is hazardous. Rise of blood pressure is overstated, being often due to precedent trouble (kidneys, heart, etc.). Pulse pressure is of concern; if high is dangerous and rises as the pulse rate falls, being often higher than the count and constituting an alarming symptom. Increasing stupor, alternations in respirations (stertrous or Cheyne-Stoke's), and rhythmic alternating restlessness (rarely mentioned in texts) are bad prognostic signs. High spinal fluid pressure is also a symptom. The best factor in determining the gravity is the way signs are going, rather than what they are at any one time. In the first four hours, one cannot usually form a sound judgment, and any radical treatment may be meddlesome. On account of shock the patient's chances are usually reduced rather than improved by operation so early. The percentage of all fissured fracture cases requiring operation is about 10 to 15 per cent, not including depressed and penetrating fractures. If there are signs of increasing intracranial pressure and hemiplegia or other focal signs, operation is demanded. Free fluid can be removed by decompression and damage, but not true edema. Free fluid may be either blood or cerebrospinal fluid. Middle meningeal hemorrhage causes slowly increasing stupor and paralysis, but is often difficult to diagnose. May have classical signs and no hemorrhage, and vice versa. Intracranial bleeding from other sources often resembles it. Subdural fluid accumulations can cause high intracranial pressure and can be relieved. Spinal puncture two to three times a day can be used to relieve pressure. If pressure and fluid return promptly after the puncture, it is a case of subdural accumulation. Hypertonic solution, as 40 cc. of a 25 per cent salt solution, injected intravenously in about twenty minutes, can be used. The maximum effect will occur for two to three hours. Do not use in manifest kidney insufficiency. Salt by mouth and epsom-salt purging is used to dehydrate, but the effect is only temporary. Salts can be given by rectum. If the pressure is high enough, do a subtemporal decompression, over the temporal bone, and also explore base and motor areas, draining for twenty-four hours.

C. E. Nixon advised small doses of morphine and spinal puncture to quiet. Prognosis generally good, if patient survives first twenty-four hours except for meningitis. Late post-traumatic neurotic symptoms show up after several weeks or months. Roy Parkinson discussed eye and ear symptoms and the slight demonstration often seen in fatal cases, Dr. David Stafford stressed the advantage of local anesthesia, H. A. Deering quoted a case with possible late cerebral lesions, and A. S. Musante presented cases of terrific impact without fracture and unilateral congenital markings in x-ray pictures, resembling fracture line. L. B. Crow closed by exhibiting illuminated "Radiograms of the Cranium," many of which were taken with a new technique by the use of a 1/10 second exposure, and advised against rushing these patients while in shock.

Case histories were discussed by R. F. Grant (perforated gastric ulcer) and Arthur Sonnenberg (pneumonia with hemiplegia). Stafford spoke favorably of the service offered by the Community Chest to hospital obstetrical patients during their first week at home. C. E. French recommended the hospital "bond" or insurance policy issued to cover hospital expenses of the insured.

Officers elected for 1925 were A. S. Musante, president; F. A. Lowe, vice-president; L. J. Overstreet, secretary; and F. C. Keck, treasurer.

The program for January 14 will include: "Indications and Contra-indications for Tonsillectomy," E. C. Fleischner; "The New Dietitian's Work at St. Joseph's," Sister M. Dionysia.

On January 22, the patronesses of St. Joseph's Hospital, Mrs. W. T. Cummins, president, will give a soiree to the student and graduate nurses at the Y. M. I. hall, and the doctors of the staff are invited.

Southern Pacific General Hospital Clinical Meeting (reported by W. T. Cummins, secretary)—The regular monthly clinical meeting was held at the Southern Pacific General Hospital, Huntington hall, on Wednesday, December 3. There were about sixty physicians present.

Scientific Program—Symposium on Heart Disease: J. Wilson Shiels, "The Old, the Young; The Ideal Attitude Towards Cardiology." He reviewed the history of cardiology and generalized on the physician's viewpoint towards the various phases of cardiac pathology, and emphasized the importance of graphic methods of study; A. W. Hewlett, "Attacks of Arrhythmia," covering the different phases of the subject, with their significance, frequency and termination, together with the value of electro-caradiographic examinations; E. S. Kilgore, "Bacterial Endocarditis," including the salient points of the bacterial and sub-bacterial stages of the infection and noting the difficulties in some cases attending the bacteriological study of the early stage; W. J. Kerr, "The Treatment of Heart Disease," with a comprehensive review of the entire subject, including the use of quinine and its derivatives selectively in some instances by intravenous injection; M. P. Burnham, "Roentgen Demonstration," comprising a number of chest plates, one of which illustrated the importance of detection of an enlarged thymus. The aorta, as well as the heart, was reviewed.

Worthwhile Work for Department of Anthropology—Doctor Saxton Pope has recently returned from an extended vacation in the mountains of Tehama, Butte, and Shasta Counties. He undertook to explore and place upon

the map the various camp sites, battlegrounds and caves of the Yana Indians, and has made a valuable contribution to the knowledge of this extinct tribe. The work was done under the auspices of the Department of Anthropology at Berkeley.

Dr. Pope is spending his sabbatical year in research work of this sort, after twenty-five years of medical practice, and intends completing his vacation with a hunting trip into British East Africa, after which he will return to the peaceful pursuits of professional life.

Successor to Doctor Rethers Appointed—Doctor Tilton E. Tillman has been appointed a member of the San Francisco County Lunacy Commission to fill the vacancy caused by the death of Doctor Theodore Rethers. The other members of the Commission are B. J. McElroy, Arthur Beardslee, and Charles McGettigan.

SANTA BARBARA COUNTY

Santa Barbara County Medical Society (reported by Alex C. Soper Jr., secretary)—The regular meeting was held December 8, at the Cottage Hospital, Santa Barbara, President Robinson in the chair. Present, twenty-two members, one intern, and two guests.

Moved, seconded, and passed that a letter be written to the editor of the Scientific American, thanking him for the work in exposing the Abrams' machine, in the name of the society.

The membership of Joseph D. Lewis, by transfer from the Minnesota Medical Society, was unanimously voted.

The matter of a doctor's telephone exchange and operator, in connection with the Nurses' Directory, was outlined by Miss Jameson, superintendent of the Nurses' Association, by Drs. Robinson, Isaac, and Mellinger, in view of a plan to have a central point where calls for physicians could be sent in emergencies. Matter referred to Drs. Lamb and Isaac for further investigation.

Five-minute case reports followed: Partial Heart Block, H. O. Koefod; Obstruction of Bowel Following Appendicitis, H. L. Schurmeier; Traumatic Rupture of Membranous Urethra, Irving Wills; The Audio Amplifier, shown by W. J. Mellinger.

Egerton Crispin of Los Angeles delivered the principal paper of the meeting—"Angina Pectoris, a Measure of Exhaustion," which was discussed by Sansum, Nuzum, Pierce, Koefod, and Means.

SISKIYOU COUNTY

Siskiyou County Medical Society (reported by C. C. Dickinson, secretary)—At the fourth quarterly meeting of the Siskiyou County Medical Society, held in Yreka, November 3, the following officers for the ensuing year were elected: President, Dr. R. H. Heaney, Yreka, Calif.; vice-president, Dr. W. H. Haines, Etna Mills, Calif.; secretary-treasurer, Dr. C. W. Ankele, Dunsmuir, Calif.

At the same meeting the application for membership in the society of David Joseph Mahan, Fort Jones, Calif., was accepted, subject to confirmation by the A. M. A. and State Board of Medical Examiners.

SONOMA COUNTY

Sonoma County Medical Society (reported by N. R. H. Juell, secretary)—The society met at Santa Rosa December 11, with seventeen members present, twenty-three absent, and two visitors.

There was no definite program; only election of officers and a social gathering.

The officers elected were: President, A. M. Thomson, Sonoma; vice-president, G. W. Mallory, Santa Rosa; secretary, Guy A. Hunt, Santa Rosa; treasurer, R. M. Bonar. Censors: (three years) S. Z. Peoples, Petaluma; (two years) E. Emerson, Santa Rosa; (one year) J. H. McLeod, Santa Rosa. Delegate, A. A. Thurlow. Alternate, M. J. Fulmer.

CHANGES IN MEMBERSHIP

New Members—Ben. F. Eager, John C. Dement, San Diego; Gerald H. Beck, George C. Brandt, R. M. Hippach, Thomas P. Manning, E. Stafford Safarik, Albert J. Scholl, Ernest W. Townsend, Los Angeles; W. Arden Fate, Santa Monica; Wallace W. Holley, Inglewood; Lawrence L. Lindsey, Hermosa; W. F. Kistinger, Santa Ana; George A. Paige, Anaheim; W. S. Wallace, Orange; Gordon E. Hein, San Francisco.

Transferred—Samuel Hanson, San Francisco County, to Alameda County; Clement H. Arnold, San Francisco County, to Canta Clara County; Robert M. Jones, Fresno County, to Kern County.

Resigned—W. D. Clark, San Francisco.

Retired—Louis Bazet, San Francisco.

Honorary Member — T. W. Huntington, San Francisco.

Reinstated—Giles S. Porter, Los Angeles.

License Revoked—Olaf A. Kvello, Los Angeles.

Deaths—Beckman, Oswald Heribert. Died at Glendale, November 28, 1924. Graduate of Jefferson Medical College, Pennsylvania, 1884. Licensed in California in 1895. He was formerly a member of the Mendocino County Medical Society, the California Medical Association, and the American Medical Association.

Dryer, John L. Died at Santa Ana, December 1, 1924, age 79. Graduate of the Cincinnati College of Medicine and Surgery, Ohio, 1877. He was a member of the Orange County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Hendricks, Hiram Porter. Died at Pasadena, September 28, 1924, age 50. Graduate of Northwestern University Medical School, Chicago, Ill., 1908. He was formerly a member of the San Diego County Medical Society, the California Medical Association, and the American Medical Association.

James, Joseph William. Died December 11, 1924, at Sacramento, age 49. Graduate of Cooper Medical College, San Francisco, 1900, and licensed in California the same year. He was a member of the Sacramento County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Rethers, Theodore. Died at San Francisco, November 21, 1924, age 57. Graduate of the University of Berlin, Germany, 1891. Licensed in California in 1892. He was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Van Tine, Cothran. Died at Selby, October 27, 1924, age 67. Graduate of Pulte Medical College, Cincinnati, 1890. Licensed in California in 1914. He was a member of the Santa Cruz County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

STIMULANTS, DEPRESSANTS, HUMOR

In reading the article in the A. M. A. Bulletin entitled "What is Wrong with the County Society" (see page 69 of this issue of C. and W. M.). That is what has been troubling me for ten years past. The —— County Medical Society during this time has been a dead letter. I, a member, have not had notice of a meeting being held for about three years, and for approximately that length of time there has been no regular election of officers. The medical men of this town are divided into groups or cliques, who are antagonistic to each other to such a degree that I doubt if any argument could get them to work in harmony. If other counties of small membership are in the same predicament—that's what's the matter with the County Society.—R. C., ——.

The Medical "Mossback," God Bless Him!

My first bit toward the education of the Mossback (old-time family physician) was done on my father," writes Roland G. Breuer (Journal of Kansas Medical Society). "It was almost my first call case—a boy of 16, with a regular afternoon temperature, higher each day, toxicity—all of the symptoms of a typical Oslerian typhoid. Promising the parents a discouraging session of six to eight weeks, I succeeded in impressing them with the gravity of the case. I permitted my father to accompany a real medical man and watch him work. With due humility he followed me, and humbly asked permission to make a cursory examination, a request which I magnanimously granted, explaining to him, the while, that in several days the Widal test would become positive—a thing which he indelicately refused to believe. However, after I gave him a good lecture, he subsided. On the following day he volunteered to stop and see the case on his way to the

office. With misgivings I gave my consent. Late that afternoon I hurried over for a specimen of blood for another Widal. The boy was sitting up; there was a sparkle in his eye, snap to his smile and a sting to his grin. A large wad of dressing was in his left axilla—my benighted father, refusing to wait for a Widal, had found an axillary abscess, lanced it, drained it, and shot a durned good diagnosis of typhoid fever all to thunder."

I have been very much interested in your editorials and consider them the best published in any medical journal, as they cover live topics, subjects that concern the doctor's future welfare, but which policy causes most medical leaders to straddle, and then a few years later when the damage has been done they make their cry. I subscribe for seven medical journals and I honestly believe that California and Western Medicine is not only the most attractive but the most valuable that comes to my desk.—M. B. W., San Francisco.

Father—Tommy, stop pulling that cat's tail.
Tommy—I'm only holding the tail; the cat's pulling it.

When all is said, the general practitioner, the real trunk of our tree, is the man who can do most at solving the problem of feeding infants.—E. M. T., Los Angeles.

Thank you very much for your recent letter and for your helpful criticisms of my paper on ——. The paper was much better for the purposes of delivery at the County Society, than it was for publication in its present form. With your kindly and valuable suggestions in mind, I shall divide the paper into two parts and make certain revisions. I realize that I have demanded far more of your time than was right, in connection with a communication, which at first sight showed its unavailability for publication in California and Western Medicine. I am fully appreciative of your kindness and I wish you to know that I have a very high regard for your judgment in the matter at hand. May I take this opportunity to tell you of ever-increasing satisfaction being felt by medical men with whom I come in contact, for our State Journal? Your untiring efforts are surely bearing fruit.—J. C., San Francisco.

Have no additions or corrections to make on my paper. I think your plan of discussion is excellent and greatly adds to the value of the paper.—W. M. H., Los Angeles.

Some time ago the editor returned a manuscript of mine, saying that if I would reduce its size he would be glad to publish it. Since that time, however, you have published an article of mine. So with your permission I will not re-submit this article, since it seems to me that it would be rather selfish on my part to ask publication of two articles in one year.—H. K. B., Los Angeles.

Dentist—So you have broken off a tooth, have you?
Patient (tough youngster)—Yes, sir.
Dentist—How did you do it?
Youngster—Oh, shifting gears on a lollypop!

I am sorry to say that I have been ill and away from my office for some ten days, returning yesterday. For that reason I am late in returning the paper at the time indicated in your letter. I trust it will not inconvenience you too greatly. I am very much interested in these papers and I hope you will not hold this against me in the future when asking members to discuss papers.—A. L. D., Torrance, Calif.

Does the Child Always Resemble the Father?

Terence—'Tis a fine kid ye have here. A magnificent head and noble features. Could ye lend me a couple of dollars?

Pat—I could not. 'Tis me wife's child by her first husband.

Popular Medical Lectures—The Stanford University Medical School announces the forty-third course of popular medical lectures, to be given at Lane Hall, north side of Sacramento street, near Webster, San Francisco, on alternate Friday evenings from January 9 to March 20, 1925. The dates, subjects and speakers are:

January 9—"Influenza and Common Colds," Dr. A. W. Hewlett.

January 23—"Migration as a Factor in Communicable Diseases," Dr. W. N. Dickie, Secretary of the State Board of Health.

February 6—"Parasitic Infections," Dr. N. E. Wayson, United States Public Health Service.

February 20—"Constipation and Auto-Intoxication," Dr. W. C. Alvarez.

March 6—"Loss of Life from Preventable Diseases," Dr. W. C. Hassler, Health Officer of San Francisco.

March 20—"Vaccines and Serums," Dr. E. W. Schultz.

The Poor Boy and Medical Education—"The medical profession must not by any circumstance of excessive costs of medical education allow its doors to be closed to the poor boy. Ways and means, endowment and gifts, must be provided for the fulfillment of his medical call," says the Cincinnati Journal of Medicine editorially.

California Board of Medical Examiners

(Reported by C. B. Pinkham, Secretary)

According to the San Francisco Herald of December 1, 1924, James William Richards, M. D., once a highly respected physician of Newark, N. J., pleaded guilty before Federal Judge John S. Partridge to a violation of the Harrison Narcotic law, and was sentenced to two years in Leavenworth prison. Dr. Richards was declared to have had a forged narcotic prescription at the time of his arrest. According to reports, on September 24, 1923, James William Richards, M. D., pleaded guilty to a narcotic charge in Los Angeles, and was sentenced to 180 days in the county jail. A citation has been served on Dr. Richards, returnable at the February, 1925, meeting, to show cause why his license to practice in the state of California should not be revoked.

Leon Hurwitz, licensed to practice in California some years ago, was recently sentenced to three years in Leavenworth penitentiary, on a charge of violation of the Harrison Narcotic Act and has been served with a citation, returnable at the February, 1925, meeting, to show cause why his license to practice in California should not be revoked.

J. C. Gancsu, posing as a doctor of medicine, was recently arrested in Pasadena on a charge of violation of the Medical Practice Act. According to newspaper reports, he had two concealed cameras in his office and thereby had taken the photographs of some one hundred patients in unconventional attitudes on his operating-table. Gancsu, while doing some electrical repair work, is reported to have taken the Ohio and California licenses of Drs. Ralph W. and Harriet C. Reynolds, having erased the name of Harriet Reynolds and written in the name of Joseph C. Gancsu; also, to have removed the Ohio seal. A reproduced copy of an Ohio license in blank was seized at the time of Gancsu's arrest; also, reproduction of the city of New York certificate of registration in blank, it evidently being Gancsu's intention to start a "diploma mill."

Francis Eugene Elmer, arrested in San Francisco, February 13, 1924, on a charge of violation of the Medical Practice Act, and who was held to answer May 21 for trial, left the jurisdiction of the court. Dr. Elmer is one of those indicted by the San Francisco Grand Jury in connection with the diploma mill frauds. He has been reported as "making himself obnoxious to the American colony" in Mexico City.

Charges against three Chinese herb doctors, recently arrested in San Francisco for violation of the Medical Practice Act, were dismissed by Police Judge Golden on November 28, 1924, on the ground of insufficient evidence.

W. L. Martin, claiming to be a graduate from the American University of Sanipractic, Seattle, Wash., arrested in Long Beach on a charge of violation of the Medical Practice Act, pleaded guilty on October 28, 1924, and was given a suspended sentence of sixty days in the county jail. A search of Martin's office disclosed, among other things, a speculum, four sounds, thirteen bottles of drugs or medicines, etc. Reports from Washington state that quo warranto proceedings to revoke the charter of the American University of Sanipractic have been instituted by the Attorney-General of the state of Washington.

Slapping Her on the Wrist—Complaint was made to CALIFORNIA AND WESTERN MEDICINE by a Visalia physician that a woman unlicensed to practice medicine was doing some dangerous things. Photographs were submitted, showing a most deplorable condition of a man's jaw, said to have been aggravated by her improper treatment.

The complaint and photographs were forwarded to the Board of Medical Examiners. Their special agent investigated and promptly arrested the woman. She was charged before a Fresno judge, pleaded guilty, and was given a suspended sentence for six months.

Correspondence

The July, 1924, number of CALIFORNIA AND WESTERN MEDICINE carried an editorial entitled "Fantastic Schemes for Formularizing and Socializing Medicine." Many messages commendatory of the editorial have been received, and one letter written on the stationery of the Public Health Center of Alameda County is as follows:

October 17, 1924.

Dr. W. E. Musgrave, Editor California and Western Medicine, Balboa Building, San Francisco, California.

My dear Doctor Musgrave—In a recent issue of California and Western Medicine (Vol. XXII, No. 7) there was an editorial headed "Fantastic Schemes for Formularizing and Socializing Medicine." The conclusions in the editorial were apparently drawn from extracts from an article, "Health Surveys in the Oakland Public Schools," in the Alameda County Public Health News (Vol. II, No. 3), as frequent quotations from this article are given. The article states, in italics, that "it is findings like these upon which parents rely to safeguard the health and lives of their children."

Knowing that it is the desire of California and Western Medicine to be entirely fair, the Board of Directors (Public Health Center), to whose attention the criticism was called, have instructed me to make a reply, knowing that your idea of fair play will be such that you will publish it.

The purpose of these health surveys seems to have been misunderstood and other parts of the article quoted overlooked. As stated in the article, "you will notice that at no time (as based upon this survey) has a diagnosis been made; merely the fact recorded that a defect is suspected." The survey is a series of simply objective tests recommended by leading specialists about the San Francisco Bay who had in mind the method in which they were to be used, and are intended to find the children that are apparently well, so that they may be eliminated from special attention.

"To verify the survey findings and to gain the cooperation of the parents in the promotion of their children's health, eleven community centers have been established. The doctor is in each of these centers one morning or afternoon a week." "With the parent or guardian of the child present, the physician makes a thorough examination." The children are seen by appointment only, and the physician himself regulates the number of appointments. Each doctor sees on an average from three to five children an hour "conferring (with the parent) as to the best way of improving the child's health. If there is a family physician or dentist, the child is referred to him by the school doctor on a form provided. If not, the parents are advised to select and consult one. Should they state they are unable to pay for medical service, they are referred to the medical social service department at the treatment clinic of the Public Health Center, a card being given stating time and place."

Yours very sincerely,
ALVIN POWELL, M. D.,
Director.

Comment—Yes, we don't.

Dear Doctor—I have just been reading the article on throat swabs in the enclosed bulletin (official bulletin, State Board of Health), and am mad.

We have enough slams from the lay health worker, etc., at present, without a member of our profession in an official position going out of his way to furnish them with ammunition.

Since when have laboratory technicians developed a system of ethics or a sense of responsibility?

Since when have the ethics and honor of the average M. D. been improved and purified by his acceptance of a political job so that he may be trusted beyond the rank and file of our profession?

I have known a health officer to put a scarlet fever patient of his own in a back room, with the sign on the door of the room; nothing on the front of the house, and then allow the sister of the patient to give music lessons to children in the front rooms.

I have known of the assistant to a health officer to hand the swab to a 7-year-old boy and tell him to take the culture, etc., etc. (Signed) DOCTOR X—.

Note—The paragraph referred to by the writer reads:

"The importance of absolute exactness in diphtheria diagnosis, made possible by correct report of cultures from the throat and nose, makes obvious the necessity of a proper technique in taking swabbings for cultural tests for diphtheria. Even so simple a procedure is often inadequately or carelessly done with a resulting report which may mislead. *Laboratory technicians* sometimes wonder if poor swabbings are not sent intentionally to obtain negative findings. For release, it has been deemed safer to have the swab taken by the *health officer* or *his assistant.*"

STATE BOARD MEDICAL EXAMINERS

Sacramento, Calif., November 6, 1924.

Re: Anesthesia.

Dear Dr. Musgrave—Our legal department has held that the giving of an anesthetic by a nurse constitutes a violation of the Medical Practice Act.

In the standardization of hospitals, does your committee make any point of this important feature; i. e., is it required that anesthetics in an approved hospital must be given by one licensed under the Medical Practice Act in the state of California?

Very truly yours,
C. B. PINKHAM, M. D.,
Secretary-Treasurer.

CALIFORNIA AND WESTERN MEDICINE

December 3, 1924.

Dear Doctor Pinkham—This is in reply to your letter inquiring whether or not we will accredit a hospital where anesthetics are given by other than licensed individuals.

In view of the fact that the Council on Medical Education and Hospitals of the American Medical Association, in consequence of your similar inquiry to them, has invited my comment upon the same point, it seems advisable to again answer this question rather fully.

We have not required that anesthetics be given only by an educated physician in our hospital betterment work, except in those hospitals purporting to teach anesthesiology.

Some years ago the House of Delegates of the California Medical Association passed unanimously a resolution recognizing the giving of an anesthetic as the practice of medicine and created an anesthesiology section in the California Medical Association. The opinion of the attorney of your Board of Medical Examiners, as well as an opinion of the Attorney-General, to the effect that the giving of an anesthetic by other than one licensed to practice the healing art constituted a violation of the laws of California was important evidence in influencing the California Medical Association to take the action it did.

Since that time, in hundreds of public addresses, letters, personal visits to hospitals, and repeatedly in CALIFORNIA AND WESTERN MEDICINE and in BETTER HEALTH, I have urged that, inasmuch as we have made anesthesiology the practice of medicine in principle, that we follow that principle to its logical conclusion in practice. This I have done as chairman of the Hospital Betterment Service of the League for the Conservation of Public Health, which committee, as you know, has by delegation of authority represented the California Medical Association and the Council on Medical Education and Hospitals of the American Medical Association for years in the hospital work in California.

With the co-operation of your board, the three Class A medical schools of the state and the members of the Section on Anesthesiology, the League was able to secure an

amendment to the California Medical Practice Act, requiring the teaching of anesthesiology to medical students. Much more has been done in a consistent, sustained effort to develop a wider appreciation of anesthesiology as a medical specialty.

However, as stated above, we have not as yet made it a *requirement* for accredited hospitals for many reasons, a few of which may be mentioned.

License—This, as you know, does not mean enough in California to warrant our using it as a basis from which to classify anything pertaining to health. There are persons whose state license probably grants them legal authority to give an anesthetic who would not be permitted to give an anesthetic or practice the healing art otherwise in any hospital accepted as an institutional member of the League or accredited by the American Medical Association. Then, too, the legal phase of the question has not been cleared up. The accuracy of the opinions of your attorney, that the giving of an anesthetic is the practice of the healing art, could be very readily tested in court and if sustained and law enforcement pushed, it would help clarify the problem. It has been, and still is easy to get evidence, and the Board of Medical Examiners is at least one of the boards charged with the enforcement of the law. If I mistake not, *there are government hospitals, as well as others, in the state where even unlicensed persons have been and are giving anesthetics.*

Other Legal Difficulties—The absence of court decisions in California and their varied trends elsewhere makes even a moral force—which is all we pretend to have—hesitate to get too far ahead of public opinion, particularly about a matter which is not of nearly the importance of other matters claiming our attention. Some superior courts have ruled that the surgeon is responsible for the anesthetist's work; others have ruled that the anesthetist is responsible whether licensed or not; others have ruled that the hospital is responsible, and there are still other slants deducible from court records.

What Constitutes an Anesthetic—There is much difference of opinion on this point. Some claim that a few whiffs of ether or gas during labor or in a dentist's office is not the giving of an anesthetic. Some would include these and the use of scopolamin and any and all of the various substances and methods used in producing local anesthesia.

Not Enough Educated Anesthetists Available—There are many places in this and other states where no educated doctor of medicine is willing to give an anesthetic except in emergencies and to selected patients. There are, of course, enough of specialists and young physicians who are willing to give anesthetics in the larger centers, but even here, as you know, many of the highly respected surgeons and obstetricians prefer their own specially trained technicians to give their anesthetics.

And so I might go on for pages telling of other facts to this many-facted problem as it has presented itself to me in my hospital and other medical economics work.

These complications in the aggregate have induced me, and those I speak for, to limit our efforts to education and persuasion, hoping that, in the course of time, we will be able to make a *requirement* of what we now cover with a *request.*

If I have failed to make my answer clear, or if there is any assistance I can give you in what I assume is the beginning of a movement for law enforcement, please call upon me.

Sincerely yours,
W. E. MUSGRAVE,
Chairman Hospital Betterment Service.

Gurdon Potter, M. D., in a letter to the editor says:

"On page 647 of the December issue you quote a surgeon as having said, 'that anyone who believed in physiotherapy was the son of a quack.' I am sorry for this man, because just such an attitude in the profession has kept it in the narrow groove it has occupied for so many years, and allowed the birth of half-baked cults to arise on every hand.

"I have been a student of the application of 'mechanical means on a physiological basis' to the correction of pathology in the human body for the past twenty years, and have been given the laugh many times for my views in the matter. However, I have yet to see it fail, if your diagnosis is correct, and you know your pathology. Richard Cabot well says 'that 50 per cent of our diagnosis is incorrect.' Physiotherapy is not a 'cure-all,' and never will be. Neither is anything else, but, brother medical man, there is some truth in physiotherapy, hydrotherapy, and other controllable agencies if you have an open mind to investigate them, and really investigate them, and not take the 'barbershop chatter' that so often passes as 'gospel' in some medical groups.

"No wonder that H. C. Wood said, thirty years ago, 'if further progress is to be made we must question the old methods and search out new, which may happily lead to more fruitful fields.' Yea, verily. At the present time the really big minds in bacteriology frankly say that we are again approaching a somewhat similar condition in that branch—or words to that effect. In the light of common sense, and for the sake of real progress—yes, for the love of Mike—wake up, get out of the rut, look things over, and if they don't prove up, scrap the whole thing—but stop, look, and listen."

Tryparsamide in the Treatment of Neurosyphilis—Udo J. Wile and Lester M. Wieder, Ann Arbor, Mich. (Journal A. M. A., December 6, 1924), attempted to determine the value of tryparsamide in the treatment of neurosyphilis, as well as to determine the toxicity and the untoward reactions of the drug, if such existed. Fifty cases of cerebrospinal syphilis were utilized. In the neighborhood of 325 injections were given to these patients. The fifty cases allow of the following differential clinical analysis: General paralysis, twenty-one cases; taboparesis, six cases; tabes dorsalis, three cases, and diffuse cerebrospinal syphilis, twenty cases. Tryparsamide showed itself of great service in causing a profound change for clinical betterment in these cases. The type of case found most favorably influenced has been the type in which least might be expected, namely, the parenchymatous type in which a considerable degree of deterioration had apparently occurred. The most striking clinical changes noted have been increase in weight, color and general appearance. In nine cases, a marked improvement of the mental state of the patient has been found coincident with the improvement in the general appearance. In five cases, the treatment was followed by clinical improvement when other forms of therapy, including intraspinal treatment, had failed. This clinical betterment is not paralleled by striking corresponding changes for the better in the spinal fluid. For this reason, it is possible that the improvement characterized by gain in weight and general appearance may be due partly to the effect of the drug on syphilitic foci outside the nervous system, as well as to the tonic effect of the arsenic content of the drug. Gastric crises and the lightning pains of tabes dorsalis have, as yet, not yielded to tryparsamide treatment in this series. It would appear that more treatment of the same type should be given in those cases in which no laboratory response has been noted, on the one hand; and that a greater period of time must elapse, on the other hand, before accepting clinical improvement as definitely evident of the therapeutic activity of the drug. With the exception of vomiting, which followed each injection in one case, in no other case was there the slightest untoward result, either from the standpoint of constitutional reaction or from that of disturbance of vision.

Another Middleman in Medicine—In commenting editorially upon another great corporation planning to practice medicine wholesale, the Illinois Medical Journal says that they are going to establish a system of industrial surgery in New York City, with its beginning a series of first-aid stations placed at intervals throughout the city. This application of "chain-store methods" to the practice of medicine by a corporation of lay people will be as appalling as it is brazen, and is a direct attack upon the health welfare of the community.

"Fifteen per cent of all pregnancies result in miscarriages, and 5 per cent in stillbirths," says Charles Herrman, secretary New York Children's Welfare Association. Three times as many deaths occur in utero and at birth, as during the first year of life.

Utah State Medical Association

SOL G. KAHN, Salt Lake City.....President
WILLIAM L. RICH, M. D., Salt Lake.....Secretary
J. U. GIESY, 512 Felt Bldg., Salt Lake City,
Associate Editor for Utah

HAPPY NEW YEAR

A new year! Always it seems to mean so much. Another twelve months, a whole wonderful chain of three hundred and sixty-five and a quarter days in which to live, and work, and serve. It is a wonderful, an exalting, uplifting thought. It fills the heart with hope. To all you men of the medical profession who follow the calling of helpful service in the great state of Utah, to all of our brothers elsewhere—A Happy New Year. We can wish you nothing better on earth.

DESERVED CONFIDENCE

Those of you who follow the daily news may have read the following, under date of Tuesday, December 2, 1924: "Five persons are charged with practicing medicine without obtaining a license." If not, read it further along in this month's notes. Here is at last a practical illustration of one of the chief functions of the State Board of Registration—an illustration of how it should work. We who practice under the law, should realize that we have a duty to the body politic beyond the mere prescribing for human ills. To relieve suffering, to halt the course of disease is a noble work; but to safeguard the man who is ill, whose life may be in danger, is as much the duty of the doctor as that of the guardian of the law who shoots a dangerous animal on the street. Times change. With the passing, in a measure, of the "family doctor"—he who was physician, friend, and advisor of his patients in the past—let us not forget that the average patient is a man or woman who needs advice—a friend as well as a physician—that he knows not as we know what is genuine, what is worthy of trust and confidence as applying to our craft. It is on this almost childlike confidence, this ignorance if you like, this unfortunate gullibility of the masses that the cults flourish and grow temporarily fat. Hence, it is to the doctor, after all, to see that the standards of the profession are maintained and raised. The doctor, through the legal channels of the state machinery and his own committees on health and legislation may serve his fellow-man and his fellow-craftsman thus. Let those who are not qualified be cast out, cut off. The unqualified physician is as dangerous to the unsuspecting dupe of his pretensions as a dangerous drug. "He who steals my purse," says Shakespeare, "steals trash. But he who steals my reputation—" And what of the man who through ignorance, false pretense, personal greed, loses a patient's life? He steals—all. More power to the committee on health and legislation in their endeavors to ferret out and bring under the law men of this sort. In so doing they are protecting the people of the state, conserving their interests and their lives. And in so doing—in beginning this new year in this fashion—let us hope that they may win, not only their own and ours, but the entire commonwealth's confidence and respect. Service is the great keynote of true human association, and how can one serve better than by safeguarding and defending human life against the wiles of that type of harpy which battens off of human pain and sickness, as the other type of harpy was supposed to batten off of human flesh. Let medicine today draw a sword of righteous indignation and, literally, protect the innocent.

Utah Notes (reported by J. U. Giesy, associate editor)—Salt Lake County Hospital Clinic Meets—The clinic of the Salt Lake County Hospital met Friday evening, November 28, at the hospital. The following subjects were presented: "Typhoids and Effect of Typhoid Immunigen," George R. Roberts; "Bladder Tumor in Child Four Years of Age," discussed by W. W. Barber and W. C. Cheney, and. "Interesting Spine Cases" by A. A. Kerr, F. D. Calogne and Foster Curtis.

Illegal Practice of Medicine Is Charged—Five persons are charged with practicing medicine without obtaining a license in complaints issued from the office of the county attorney. Those named are Vonner E. Raymond, Alma S. Ash, Albert T. Faerber, Harold Hulme, and Spyros J. Parthenon.

Community Clinic Ends Busy Year—At the annual meeting of the Community Clinic and Dispensary, reports were presented by Harold M. Stephens, president; Miss Eva Hollis, treasurer; Dr. George W. Middleton, managing trustee; and by Mrs. M. S. Avery, executive secretary.

Following the reports, a resolution of respect for the late A. N. McKay was passed, and also a resolution thanking the Salt Lake County Medical and Dental Societies, who furnish the entire clinic staff.

The following trustees were elected: W. W. Armstrong, Dr. A. J. Hosmer, H. N. Byrne, F. M. Critchlow, and Harold M. Stephens. Following the regular meeting of the clinic, the board of trustees met to elect the new officers for the coming year, who were elected as follows: President, Harold M. Stephens; vice-president, Amy Brown Lyman; secretary, W. N. Williams; treasurer, Mr. Fitzpatrick, to succeed Mr. McKay.

Reports given at the meeting showed that a total of 3184 patients had been treated during the year, of which 1118 had never before received treatment from the clinic, while 2066 were patients who were returning for additional treatment. The report on the character of the treatment given showed 833 medical cases, 572 surgical, 1459 eye, ear, nose and throat, and 320 dental; also, 74 radium treatments. The patients sent to hospitals numbered 253, four of these receiving major operations, and 249 receiving minor operations.

The Salt Lake Community Clinic and Dispensary was founded by a number of business men of Salt Lake, of which the late A. N. McKay was one, for the purpose of giving free medical attention to those unable to secure it for themselves.

A Family Doctor One Hundred Years Old—Friends Honor Pioneer Utah Physician—The Centennial anniversary of Dr. Harvey C. Hullinger was recently celebrated in Vernal, Utah. Dr. Hullinger was born fourteen years after Lincoln, and was 2 years of age when Thomas Jefferson died. He came to Utah from Iowa in 1859, and served in the Civil War as a physician.

The celebration was probably the largest birthday party in the history of his county. The honor guest was presented with a leather chair, as a gift from the community. The large building was packed to capacity and many pioneers were present, as well as young people.

Dr. Hullinger made a touching address, and throughout the day refused to allow anyone to assist him as he moved about. He would say, "Don't take hold of me, you might pull me down." Dr. Hullinger has living twenty-five grandchildren, eighty-one great-grandchildren, and twenty-four great-great-grandchildren.

Dr. Hullinger received the following message from President Coolidge: "Dr. Harvey C. Hullinger, Vernal, Utah: My congratulations to you on this remarkable anniversary occasion. You have my sincere wishes that you may celebrate many returns of the day."

He also received telegrams from Governor Charles R.

Mabey, Congressman Colton, President Heber J. Grant, and many others. He was escorted about town by Messrs. McGraw and McPherson of Salt Lake City, in a beautiful new automobile.

According to Special Order No. 171, Headquarters 104th Division, United States Army, dated December 6, 1924, paragraph 6, Major John U. Giesy, Med. O. R. C., Felt building, Salt Lake City, Utah, is relieved from the 413th Infantry and is assigned to Headquarters 329th Medical Regiment as Division Medical Inspector.

Salt Lake Society—Secretary Critchlow makes an interesting 1924 annual report that might well be studied by county medical societies everywhere:

Number of regular meetings held, 18, including this meeting; number of special meetings held, 1; number of meetings open to the public, none; number of meetings held at hospitals, 3; largest attendance at meetings, 104; smallest attendance at meetings, 41; average attendance at meetings, 60; largest attendance of visitors at meetings, 24; smallest attendance of visitors at meetings, 1; average attendance of visitors at meetings, 5; number of clinical cases shown other than at hospitals, 17; number of papers read by members, 28; number of papers scheduled and not read, 2; members on 1923 roll, 209; members left town in 1923, 2; members paid dues in December, 1923, 5; members admitted in 1924, 19; grand total for year, 231; members moved from town in 1924, 2; members died during 1924, 4; members suspended for non-payment of dues, 1; active members this date, including honorary members, 224.

Members Elected—Fifteen, as follows: Newton Miller, F. G. Eskleson, George E. McBride, E. R. Van Cott, J. Clinton Bown, Burtis F. Robbins, Scott A. Jones, Edwin R. Murphy, Sam G. Paul, William R. Cannon, F. K. Root, M. Skolfield, G. H. Pace, S. H. Besley, Charles W. Woodruff.

Members Elected by Transfer—Four, as follows: D. W. Henderson, Juel E. Trowbridge, R. O. Porter, G. Wallace Hanks.

Deaths—Death has taken a heavy toll from the society during the year 1924. L. B. Laker of Eureka, Utah, died February 7, 1924, following an operation. J. Lane of Salt Lake City died of pneumonia March 18, 1924. J. F. Critchlow, Salt Lake City, died in an automobile accident July 24, 1924. Ernest Van Cott of Salt Lake City died of angina pectoris August 27, 1924. Patrick S. Keogh, an ex-honorary member, died November 25, 1924, of uremia.

Officers—The following officers have served during 1924: President, A. A. Kerr; vice-president, John Z. Brown; secretary, M. M. Critchlow; treasurer, J. E. Jack.

Board of Censors—T. A. Flood, term expires 1924. E. D. Hammond to serve one year. F. A. Goeltz to serve two years.

Delegates Whose Term Expires in 1924—E. F. Root, E. D. Hammond, W. G. Schulte, F. F. Hatch, J. Z. Brown, J. P. Kerby, J. E. Tyree, F. A. Goeltz, T. A. Flood.

Holdover Delegates—A. A. Kerr, E. M. Neher, C. L. Shields, V. J. Clark, A. C. Behle, W. R. Tyndale, H. P. Kirtley, F. B. Steele, J. C. Landenberger, M. M. Critchlow, Ernest Van Cott (deceased), W. R. Calderwood, D. L. Barnard, etc.

Alternates—W. F. Beer, F. E. Straup, T. B. Beatty, Clifford Pearsall, David Smith.

Committees

Public Health and Legislation—Ernest Van Cott, chairman; R. R. Hampton, J. J. Galligan. When Ernest Van Cott died, Dr. R. R. Hampton was made chairman and Sol G. Kahn was appointed on the committee.

Library Committee—W. R. Tyndale, chairman; George F. Roberts, B. E. Bonar, F. J. Curtis, E. M. Neher, F. B. Steele, F. A. Goeltz, R. T. Richards.

Program Committee—A. A. Kerr, chairman; M. M. Critchlow, secretary; John Z. Brown, F. E. Straup, John R. Llewellyn, E. D. LeCompte.

To Investigate Institutions Caring for Charity Patients—W. R. Calderwood, chairman; M. M. Nielson, Thomas E. Clark.

Auditing Committee—E. D. LeCompte, chairman; A. A. Kerr, L. N. Ossman.

Broadcaster for Hygeia—Willard Christopherson, succeeded by T. B. Beatty.

Community Clinic Committee—George W. Middleton, chairman; A. J. Hosmer, W. Christopherson, F. E. Straup, J. F. Critchlow, succeeded by A. C. Behle.

Medico-Legal Committee—E. F. Root, chairman; H. P. Kirtley, J. C. Landenberger (three years); A. C. Behle, S. H. Allen, W. S. Ellerbeck (two years); M. L. Lindem, C. L. Shields, F. Leaven Stauffer (one year).

Building Committee—M. M. Nielson, chairman; W. R. Calderwood, Fred Stauffer, E. F. Root.

Medical Liability Insurance Committee—B. W. Black, chairman, resigned March 12, 1924; Sol G. Kahn, appointed chairman, March 12, 1924; F. A. Goeltz, S. D. Calonge.

Aschoff Committee—G. G. Richards, chairman.

Disabled Veterans' Committee—L. J. Paul, chairman; S. C. Baldwin, R. J. Alexander, W. F. Beer, J. U. Giesy.

Receipts

Members paid $10 each, 202	$2020.00
Members paid $12 each, 20	240.00
Sale of caducei, 26 at $1.25	32.50
Turned over to treasurer	$2292.50

The officers wish to thank the members who have served so faithfully on committees and who have cooperated to make the scientific programs a success. All committees have been active, but the Committee on Public Health and Legislation and the Library Committee deserve special praise for their untiring efforts.

At the last meeting in 1923, the by-laws were amended so that members not having paid their dues by February 1, 1924, were considered delinquent and the dues automatically raised to $12.

On January 28, 1924, the by-laws were amended so that a medico-legal committee became one of the standing committees. The function of this committee is to advise with the defendant in any malpractice suit; to survey the evidence and the elements of the treatment; to appoint witnesses in the defendant's behalf; to adjudicate the question of fight or compromise; to advise with witnesses for the prosecution in malpractice cases; and to arrive at a conclusion as to the merits of such a case. Also to advise with medical experts in personal injury and corporation cases with the idea of promoting substantial justice. To attend the trial as spectators in person or by proxy all cases bearing medical testimony, either "malpractice" or "personal injury"; to listen carefully to such testimony and later review it among themselves; and finally, to prefer charges before the society against any member who makes statements contrary to modern scientific knowledge.

In view of the fact that the society has grown and now is a powerful organization, the present officers recommend that an office of historian be created so that records of the society may be kept from year to year in a concise form.

December 8, 1924.

Minutes of the Salt Lake County Medical Society (reported by M. M. Critchlow, secretary)—The program of the November meeting of the Salt Lake County Medical Society was a symposium on contagious diseases. The first paper was given by William A. Pettit on the "Differential Diagnosis of Contagious Diseases." Scarlet fever, measles, recurrent scarlatina, epidemic exfoliative dermatitis, German measles, drug eruptions, chickenpox, and smallpox, were thoroughly discussed. The paper was discussed by Drs. Beer, Jeidell, Day, and Calonge.

The treatment and sequelae of contagious diseases were dealt with in the paper by William C. Cheney. He took up post-diphtheritic polyneuritis, the various sequelae of scarlet fever and measles, smallpox, and mumps. He discussed the treatment of diphtheria, scarlet fever, and whooping-cough. This very interesting paper was discussed by Drs. John Z. Brown, McHugh, Calderwood, Peterson, Scott, Pettit, Jeidell, Lipkis, Calonge, and Major S. C. Gurney.

Earl Van Cott announced the death of Dr. C. M. Hart. Sol G. Kahn reported for the Committee on Public Health and Legislation, and gave his views on advertising. Fred Stauffer reported for the Committee on the Doctors and Dentists' Building. He exhibited plans for a new building, to be put up on the south side of South Temple, between Main and State, and related the plans for erecting such a building. This building is to be used by doctors and dentists, all except the first floor which is to

be rented. Discussed by W. R. Calderwood, M. M. Nielson, Fred Stauffer, and J. A. Phipps. W. R. Calderwood moved that the society declare itself in favor of the proposed building, and the committee be authorized to proceed with the plans. Seconded and carried. Further discussion by F. S. Scott, M. M. Nielson, F. H. Raley, and J. A. Phipps.

Resolutions on the death of Patrick S. Keogh were read by the secretary. It was moved by Warren Benjamin that the resolutions be adopted. Seconded and carried.

R. O. Porter announced that a railroad company had an opening for a physician out of town, and anybody interested should communicate with him.

A communication was read from Mrs. L. N. Ossman which stated that the Ladies' Auxiliary would hold a tea at the home of Mrs. J. C. Landenberger, December 3, 1924.

Annual Meeting—The annual meeting of the Salt Lake County Medical Society was held at the Commercial Club, Salt Lake City, December 8, 1924. The meeting was called to order by President A. A. Kerr. Seventy-seven members and one visitor were present. Minutes of the previous meeting were read and accepted, with one correction, as follows: "That the society declare itself in favor of the proposed building, and the building committee be authorized to proceed with plans for a building."

A clinical case of hare lip and cleft palate which had been operated was presented by S. H. Allen.

Applications for membership, signed by Lyman M. Horne and J. E. Morton, were read and referred to the board of censors.

President Kerr read an address, setting forth the work done by the society during the past year.

M. M. Nielson and Fred Stauffer reported for the building committee, and three plans were submitted. Mr. Vincent spoke a few minutes on his proposition to erect a $600,000, eight-story building on First South, between State and Second East, to be partly financed by physicians and dentists, and used by them exclusively, at about $1.75 per foot.

Thomas Boise of the Hogle Investment Company spoke on their proposition to erect a building on the corner of First South and State, to be leased to physicians and dentists only, at approximately $1.75 per foot. Discussed by L. J. Paul, Fred Stauffer, and G. A. Cochran. Claude Shields moved that the various propositions be submitted in writing to the building committee, and that the committee should report to the society with their advice. Seconded and carried. M. M. Nielson wished a standing vote of those in favor of the doctors and dentists' building. All stood up.

Fred stauffer reported for the banquet committee, and suggested that the banquet in honor of Salathiel Ewing will be held December 29, 1924, and the admission to be $3.

The secretary's annual report was read and accepted.

The report of the treasurer, Joseph E. Jack, was read and accepted.

E. F. Root reported verbally for the Medico-Legal Committee.

W. R. Tyndale reported for the Library Committee, and recommended that $600 be allowed annually for the library fund. The report was accepted.

M. M. Nielson reported, in place of W. R. Calderwood, for the Committee Investigating Charity Institutions. He read two legal opinions in regard to charging patients who are able to pay for physicians at the Salt Lake County Hospital by outside practitioners. Discussed by F. E. Straup. It was moved that the report be accepted. Seconded and carried.

Sol G. Kahn read the report for the Public Health and Legislation, which was accepted.

L. J. Paul reported for the Disabled American Veterans' Committee, and his report was accepted.

The following officers for the year 1925 were elected: John Z. Brown, president; F. H. Raley, vice-president; M. M. Critchlow, secretary; Joseph E. Jack, treasurer; A. A. Kerr, censor.

Fred Stauffer and F. H. Raley conducted President Brown to the chair. After a short speech by the new president, the meeting adjourned at 10:40 p. m. and refreshments were served.

M. M. CRITCHLOW,
Secretary.

Nevada State Medical Association

W. M. EDWARDS, M. D., Mason.....President
CLAUDE E. PIERSALL, M. D., Reno.....
Secretary-Treasurer and Associate Editor for Nevada

Washoe County Medical Society (reported by Vinton A. Muller, secretary)—The Washoe County Medical Society met in regular session in the rooms of the Chamber of Commerce, Reno, December 9, President R. H. Richardson presiding. The minutes of the previous meeting of November 11, 1924, were read and approved.

Communications—Two letters of condolence, which had been sent to Doctor David L. Shaw in connection with the death of his mother, and to Mrs. John Lewis in connection with the death of Doctor Lewis at the time of their passing, were read to the society, whereupon it was voted that these resolutions be adopted and spread upon the minutes.

Program—Doctor J. La Rue Robinson presented a paper on the extraction of magnetic foreign bodies from the eye by means of the giant electric magnet. He presented three case reports and demonstrated to the members of the society a magnet of his own design which differed primarily from the magnets upon the market, in that it possessed an armature which greatly intensified the pull of the magnetic tip. The magnet is operated by a six-cell storage battery. There were several questions asked by Doctors Albert, Piersall and others, which were in turn answered by Doctor Robinson.

C. E. Piersall, the secretary of our State Association, having recently returned from the meeting of the secretaries of the state medical societies in Chicago, rendered a report on the activities of this meeting.

Election of Officers for the Ensuing Year—The chairman announced that the election of officers for the year of 1925 was in order and called for nominations.

Doctor Tees nominated Vinton A. Muller for president. Nomination was seconded by C. E. Piersall, after which on motion duly seconded and carried, the rules were suspended and the secretary instructed to cast the unanimous vote of the society for Doctor Muller for president for 1925. C. W. West next nominated Doctor Piersall for the office of vice-president, which nomination was seconded by Doctor Pickard, after which on motion duly seconded and carried the nominations were closed, the rules suspended, and the secretary was instructed to cast the unanimous vote of the society for Doctor Piersall for vice-president for 1925. Doctor Piersall next nominated Doctor Horace J. Brown for the office of secretary-treasurer. Doctor J. L. Robinson in turn nominated Doctor Henry Albert for the same office. Doctor Albert declined the nomination, but this was not accepted by the society, whereupon ballots were passed and a vote taken, with the result that Doctor Henry Albert was elected to the office of secretary-treasurer for 1925. C. E. Piersall was next nominated and elected as censor for two years, and C. W. West as censor for three years.

Officers-elect for 1925, therefore, are as follows: President, Vinton A. Muller; vice-president, C. E. Piersall; secretary-treasurer, Henry Albert; censors for one year, S. K. Morrison; censor for two years, C. E. Piersall; censor for three years, C. W. West.

Doctor Ajika Amano, who has filed application for membership in the society, being present as a guest at this meeting, was formerly introduced to the members.

Attendance—Members: Richardson, Albert, Robinson, Walker, Piersall, Pickard, W. H. Hood, Robison, West, Adams, Servoss, Tees, Morrison, Muller. Guest: Ajika Amano.

Before placing the motion of adjournment in order, Doctor R. H. Richardson, as retiring president of the society, gave a short closing speech.

Nevada Medical Bulletin Notes (edited by C. E. Piersall, Reno, Nev.)—You will see in the next few issues of the Bulletin of the American Medical Association what was said and done at the recent conference of the state secretaries.

There are 145,000 M. D.'s in the United States and

only 90,056 members of the American Medical Association, and that 40,000 of them are indifferent about organization and progress is all worth knowing, and the reason for such statistics is most important to us.

At our 1925 state meeting at Elko, we will have a paper about "The Workings of the American Medical Association." This should create interest where now there is indifference.

Read on and see what Dr. Harris said about Direct vs. Indirect Medical Service and Dr. Haggard's message on Periodic Health Examinations. You may obtain articles on and examination blanks for physical examination of apparently healthly persons, from the American Medical Association.

The graduate extension work being carried on by several universities and proposed to be done by the American Medical Association will save us time and money by bringing the teachers to us.

More clinics and case reports are advocated for our county and state programs.

Remember that the American Medical Association is not only a group of officers; it is you and I. What would American medicine be without this organization? Belong and boost. Read the Journal and Bulletin. Subscribe for Hygeia for your clientele, your city library, your politicians.

What subjects do you want presented and discussed at Elko next fall? What subject will you present or discuss? After the program is arranged it is too late to say "Why was I not listed for discussion or a paper?"

California Northern District Medical Society (reported by Charles J. Durand, secretary)—The thirty-seventh semi-annual meeting of the California Northern District Medical Society was held in Sacramento on November 25, 1924, C. E. Schoff, Sacramento, president, and C. J. Durand, Colfax, secretary.

The morning session was devoted to clinics of the Sacramento Hospital:

Surgical, by J. B. Harris, M. D.; A. K. Dunlap, M. D. Medical, by F. F. Gundrum, M. D.; F. N. Scatena, M. D. Urological, by N. G. Hale, M. D.

At the afternoon session, Dehydration in Infancy and Childhood was discussed by Edward S. Babcock, M. D., Sacramento; The Kidneys in Pregnancy, by Alice F. Maxwell, M. D., San Francisco; Practical Points in the Diagnosis of Gastro-intestinal Disease, by Walter C. Alvarez, M. D., San Francisco; Practical Considerations of Sinus Diseases, by Joseph O. Chiapella, M. D., Chico; and Pyelography in Its Relation to Urology, by Nathan G. Hale, M. D., Sacramento.

At the closing business session, the following officers were elected: President, Charles J. Durand, Colfax; first vice-president, J. R. Snyder, Sacramento; second vice-president, Oscar Johnson, Sacramento; third vice-president, Dewey Powell, Stockton; secretary, J. O. Chiapella, Chico; treasurer, O. Stansbury, Chico; board of censors, James H. Parkinson, Sacramento; J. D. Dameron, Stockton; D. H. Moulton, Chico; Charles E. Schoff, Sacramento; George J. Hall, Sacramento.

California Association of Medical Social Workers (reported by C. Ruth Hersey, secretary pro tem.)—At an executive meeting held November 21 at the Children's Hospital, the following new members were elected: Miss Alice M. Keene, Director Health Center, St. Luke's Hospital; Miss M. Meininger, clerical assistant, Mount Zion dispensary; Miss Margaret M. Lindsay, Stanford Women's Clinic; Erla I. Ninnis, Skin Clinic, Stanford Hospital; C. Ruth Hersey, head worker, Medical Clinic, Stanford Hospital; Abbie Carleton Doak, Children's Clinic, Stanford; Ida Schoenitzer, district nurse, San Bruno clinic. Ruth Cooper, County Charities, Los Angeles.

The president reported seven favorable answers to fourteen letters sent to possible candidates to membership in Southern California.

The Army Wants Doctors—On January 12, 1925, an examination will be held for the selection of medical officers of the United States Army. Those interested may secure additional information from any military organization.

Medicine Before the Bench

FINDINGS AND COMMENTS OF THE COURTS ON ACTS AND OMISSIONS OF DOCTORS

[EDITOR'S NOTE—*The law reports contain many interesting decisions, involving the reputations and fortunes of doctors. In this column in each issue a brief summary of one or more decisions and comments of the several courts of last resort upon the cases will appear. The matter will be selected by our general counsel, Hartley F. Peart, who, with Mr. Hubert T. Morrow, attorney for Southern California, will contribute from time to time.*]

In a case cited with great frequency before the courts, it appeared that the defendants were licensed physicians and surgeons practicing as partners. One of them, Dr. S., amputated the right leg of the plaintiff, the patient dying a short time thereafter. The representatives of his estate secured a verdict before a jury, from which verdict an appeal was taken. It appears that the body of the deceased plaintiff was exhumed at the instance of the deceased's administrator to determine just what the condition of the bones were, and a portion of the bones of the plaintiff were produced in court. The Supreme Court of the state in which the action was tried, in passing upon the case, wrote an opinion which has become a classic. We quote from a portion of it, as follows:

"A final and practical reason for the exception to the ordinary rule in negligence cases is the inherent and inevitable uncertainty of available testimony. The basis of the proof of negligence and of the hypothetical questions to plaintiff's experts is, naturally, the narrative of the family or friends of the patient. Their testimony must ordinarily be unsatisfactory, because of the presence of natural bias, the absence of technical knowledge essential to proper observation, and often the want of opportunity for actual perception, as will presently appear in this case. 'The physician,' said Judge Upton, 'is liable to have his acts misjudged, his motives suspected, and the truth colored or distorted, even where there are no dishonest intentions on the part of his accusers. And from the very nature of his duty he is constantly liable to be called upon to perform the most critical operations in the presence of persons united in interest and sympathy by the ties of family, where he may be the only witness in his own behalf.' This is not necessarily, however, the greatest of the surgeon's tribulations. He is confronted by other uncertainties in testimony greater than those of the human constitution, however fearfully and wonderfully we may be made or act, and greater than those of physical science, however elusive it may be. He is faced by the eccentricities of medical experts. We have no inclination to share in the prevalent and intemperate denunciation of their unreliability and venialty. But if every verdict mulcting a reputable physician in damages must be sustained, if any of his professional brethren can be induced to swear that, assuming the testimony of the family and friends of the patient to be true, the physician had made a mistake of judgment or had been guilty of unscientific practice, then the profession would be one which 'unmerciful disaster follows fast and follows faster.'"

Whose Doctor Are You?—"Nearly every industrial concern employs some doctor," notes Samuel E. Earp (Journal Indiana Medical Association). "Every department store, hotel, fraternal and civic organization also has its own doctor. Most of these physicians receive a nominal fee. A general practitioner is called to see none of these sick persons, and hence he does less practice than in former days, and the newer generation feels the effect more than do those who have been established for a number of years and do work as consultants."

Medical Economics and Public Health

Oregon Defeats Health Insurance—The most complete and drastic scheme of Universal Compulsory Health Insurance yet devised was on the Oregon ballot this year, and was defeated by about three to one. The initiative was craftily drawn as an amendment to the Industrial Accident law, and would have placed the complete control of all agencies of scientific medicine under a political board.

The most interesting feature of the fight, which was carried forward in the usual crusading manner, was the line-up of the forces. *Many so-called health and welfare groups were strongly with the socialists.*

Public Health Ideals—In discussing this interesting topic, as compared with current procedures in England, Doctor R. A. Lyster (Lancet) says:

"The separation of the medical work of the Board of Education from the Ministry of Health is just as complete as ever, *and any alleged unification in that direction is merely make-believe.* It has long been an established ideal of this society that practical unification in this direction is urgently necessary, and I have no doubt that during the coming session the prosecution of this campaign will be continued.

"Local unification of medical services is still a pressing need. All public medical work should be combined in one department under one head, and as far as possible controlled directly through one committee of the local authority.

"At the present time the Ministry of Health and the Board of Education are paying large sums of public money direct to county nursing associations, district nursing associations, welfare centers, and all kinds of voluntary associations, with results that are deplorable from the economic expenditure of public funds and the point of view of efficiency of organization.

"The strangle-hold of the big voluntary associations upon public health work has become one of the dangers of health work. No one appreciates or values more highly than myself the valuable work accomplished by small local associations for after care of tuberculous persons and defective school children, and also by those voluntary workers attached to maternity and infant welfare centers all over the country. These deserve the highest praise and every possible encouragement, but the big associations and "national councils," with whole-time paid officers (a curious kind of "voluntary" work), invariably attempt work which, in my opinion, is far better done by officers employed and controlled directly by local authorities.

"The ideal that public administration should be carried on by public officers and not by voluntary associations can only be departed from with grave danger to the state and to the individual.

"It is a curious mentality which puts a halo round self-appointed members of so-called "voluntary associations" and their (usually unqualified) officers.

"There has been a constantly increasing public danger due to a growing inclination on the part of the central authority to make rules and regulations for all sorts of detailed conditions, and to exercise a supervision over minutiae of administration which, if successfully established, can only result in a degradation of local government. This pernicious tendency is the cause of an increasing irritation on the part of local government officers and local authorities. It is gratifying to be able to record the fact that recently the Prime Minister, and also the Minister of Health, expressed opinions that *the powers of local authorities should be greatly increased, and that there should be greater freedom in local government.*"

Government in Business—"The tendency of government has been, during the past decade or so, to rush headlong into business," writes Paul Shoup (California Journal of Development). "In doing this it has the great advantage over private enterprise, and a great disadvantage as well, in that it does not have to succeed to keep going. It does not have to justify itself on economic grounds. It may operate a gas plant, run a street railroad, conduct a waterworks, and lose vast sums and yet not be held accountable, for it has the resources of taxation to make up deficits of all kinds, whether the causes of these deficits have been incapable management, profligate wastefulness, or direct dishonesty. Private enterprise must be conducted economically and must justify itself in a business way or fail."

The unanswerable force of this argument still applies if "medicine" is substituted for "business."

"Shall the medical profession vend its products directly to the consumer or shall it sell them to a middleman or third party?" was discussed (House of Delegates, A. M. A.) from the standpoint of what is best for the public as well as from the standpoint of the ultimate effect on the independence and the welfare of the physician as a result of "dealing through a jobber or middleman." This presentation was placed before the House of Delegates by the Judicial Council, because, as stated in its report, lay organizations are offering periodic medical examinations to the public for a stated sum per annum, the examinations being made by physicians who receive from these organizations a much smaller sum than is charged the person examined and who report their findings, not to the examined, but to the officers of such organizations. The council having expressed its disapproval of the methods and the general activities of lay organizations in the field of periodic health examinations was sustained in its position, that *"the proper person to make such examinations and to give advice relative thereto is the family physician, aided, when necessary, by local specialists."* The House of Delegates adopted the following resolutions, after consideration of the matter as a Committee of the Whole:

RESOLVED, That the Committee of the Whole recommends to the House of Delegates that the practice outlined in the supplementary report of the Judicial Council be condemned as against the best interests of the public; and be it further

RESOLVED, That the Judicial Council be instructed to carry on an educational campaign in conjunction with the constituent state associations and to co-operate with other councils and bureaus of the American Medical Association in the promotion of periodic health examinations by family physicians.

If county societies or individual members wish further information, they should communicate with the secretary of the California Medical Association.

Medical Charles Darwins Needed—"What we need today a good deal more than a larger number of research workers is a medical Charles Darwin who could correlate the innumerable detached scientific truths applicable to the practice of medicine already discovered and show us how these can be put to more general practical use," believes E. H. Ochsner. "No one will ever be able to accomplish this important task who does not know medicine from every angle, including the economic angle."

Rockefeller Foundation in a New and Splendid Service—The prefatory note in the first issue of a new series of publications explains the very commendable purpose and the methods by which the Rockefeller Foundation proposes to assist the cause of medical progress by bringing together ideas not otherwise widely available.

"In the present period of unprecedented progress and readjustment in medicine, the problem of the dissemination of information is becoming increasingly difficult and perplexing. In the field of research, productive effort is so abundant that it is quite impossible for an investigator to keep in touch with general literature except through abstracts or reviews. Moreover, lengthy papers, and especially those dealing with problems of administration, equipment, methods and maintenance of laboratories and clinics, are year by year more difficult of publication. This is especially true of contributions in the field of medical education, which, in that they are fundamental to all progress, are in the long run of prime importance. Plans of new buildings, methods of instruction, and experiments in teaching are usually published in local journals or for distribution as commemorative volumes in

connection with a dedication or inauguration of new facilities. Such material, naturally, is not widely disseminated. Likewise, the traveler to other countries, interested though he may be in fundamental problems of medical education and returning with first-hand information of new buildings, and new methods, can reach only a few associates or perhaps the staff of a single institution.

"To avoid some of these difficulties, it has seemed advisable to the officers of the Division of Medical Education of the Rockefeller Foundation to collect and publish from time to time brief descriptions of clinics, laboratories, and methods of teaching in different parts of the world in order that the information in convenient form may be brought to the attention of those most interested. It is hoped that the material may be of assistance to those planning improvements in buildings and methods."

Fake Health Literature—"The New York Department of Health calls attention to the fact that health articles containing advice on how to keep well are now copied as to style by the manufacturers of cure-alls and fake remedies of every description. Under these circumstances it is difficult for the public to recognize the true from the false and be able to protect itself from the snares of the fakir," says the Indiana Medical Journal editorially.

When the Frost is on the Pumpkin and the Fodder's in the Shock is the time for county fairs and with them the inevitable baby contests. Of course, these baby shows put on in the guise of promoting children's health are, for the most part, sponsored by lay persons, but nevertheless in order to give them an air of trustworthiness and finality some very reputable and experienced physicians will be called upon to give their time gratuitously for about a week to the main idea of telling fond mothers whether their pot-bellied youngsters are getting well balanced rations or not, or suffering from anything from hives to infantile paralysis. The big idea is to have a good show that will attract mothers and get a lot of very valuable free advice from some very reputable physicians, and it does not make any difference whether the candidates are able to pay or not.—Indiana Medical Journal.

Dangerous Advice—"Shall the health officer expect the nurse to diagnose communicable disease? Certainly not. But he does expect her to be alert for its possible presence and to *report her suspicions for his (health officer's) confirmation, even in cases under the care of physicians,*" says J. J. Sippy, Executive San Joaquin Health District (Pacific Coast Journal of Nursing). "Physicians resent this at times, but the responsibility is not hers as a nurse but as the health officer's assistant or deputy, and so long as cases of smallpox continue to be diagnosed as 'Cuban itch,' scarlet fever as 'stomach rash,' and diphtheria as 'croup,' we all know that some physicians have their limitations in diagnosis, and that *regardless of their sensitiveness they must expect some official intervention if these diseases are to be controlled.*

"Even the ultra-conscientious and capable physician may at times be unaware of the prevalence of diphtheria in a locality and thus overlook a mild diphtheritic tonsillitis, *the true diagnosis of which the nurse, with her knowledge of other contacts positively diagnosed as diphtheria,* can rightfully suspect. In fact, there is symptomatically nothing so obscure about most of the contagions, which the well-trained nurse with keen observation and experience with large numbers of cases is not in a position to *diagnose almost as accurately as the average physician* whose experience is limited to the occasional case."

The taxpayers of California, in county, municipal, state, and national taxes in 1923, paid considerably more than $500,000,000 in taxes, or substantially the *value of all the products of the soil of the state, fruit, and farming in their raw state.*—California Journal of Development.

These figures include the Sheppard Town (er) and Country practice.

The Editor Illinois Medical Journal Believes That what the colleges want and what the country and profession needs is the study of medicine so arranged that a man of intelligence, of moral principle, and of talent for medicine, can learn how to make sick people well, and how to teach well people how to keep so. There is now too much detail, too much preparation, too much red tape, and an absolute lack of balance. What the public wants urgently is a replenishment of the ranks of old-fashioned doctors. Until this is done the study of medicine will continue to dig its own grave.

Health Examinations—After giving the problem of periodic examinations serious consideration, the committee of the Massachusetts Medical Association, among other important findings, believes (Boston Medical and Surgical Journal) "that unless the profession at large can and does carry out health examinations the real object of health examinations cannot be obtained. . . .

"While it is true that in some of the more elaborate plans for conducting physical examinations several specialists participate in each physical examination, the committee feels strongly that, as a general policy, it is much sounder if the examined individual is regarded as an entity by one physician rather than as a collection of segments with each of these segments a province of a different physician. . . .

"The committee would like to see the general practitioner in rather more complete charge of his patients both in illness and in health, not because it might seem to be of benefit to the physician, but because the committee believes that it would be of great benefit to the patient. . . .

"The committee believes that the medical profession is and must be the very foundation stone of public health, and is inclined to look askance at certain tendencies to separate widely the functions of curative medicine and preventive medicine. Always there will be, of course, specialists and leaders, but the general practitioner should practice preventive medicine as he practices curative medicine."

Hospital Association Among University Students—The University of Illinois (The Nation's Health) claims the most thorough and complete medical service to all students largely at state expense.

The essayist, Joseph F. Wright, believes other universities will copy their system. "The plan for the student health work is carried out in three closely related but distinctly separate departments: the medical department itself, the department for physical training, and the one for general athletics. . . . Most medical attention to students is carried on by the university at state expense, and the work in this department is one of the outstanding things at this university. . . . Most of the work is done by the corps of six university physicians, four of whom attend to the health of the men students, two to the women.

"In connection with the health service there is a hospital on the campus expressly for student use. *Many of the students belong to the hospital association, membership in which costs $3 each semester.* This minimum fee entitles the member to all the care furnished by the university hospital, without further cost."

The Need of a Course in Medical Economics in Every Medical College—Today the average medical student is well grounded in the fundamental sciences underlying the practice of medicine. This is acquired at great expense of time and money. The student leaves his alma mater less well prepared in the art of medicine and utterly unprepared to handle those problems which are quasi-scientific in nature, with the result that either he flounders around for from five to ten years until he works out these problems for himself or accepts some poorly paid position in a health department or industrial concern or gives up in despair and leaves the medical profession in order to enter some other vocation.—E. H. Ochsner.

Yes, We Do Not Practice Medicine—An essayist (Pacific Coast Journal of Nursing) illustrates how nurses do not practice medicine, by telling of an instance where a teacher reported to the nurse that pupils had an itching eruption.

"Upon inspection of the pupils, the nurse found that eleven out of fifteen pupils had either im-

petigo or scabies. What was she to do? The parents would not take these children to a physician nor would they have a physician come out —$70 for scabies—it isn't done. The nurse had gotten permission from the county physician to use ammoniated mercurial ointment for impetigo, sulphur ointment for scabies, and always had a supply with her for such emergencies as this. The children usually paid from 10 to 15 cents for a very small box of the ointment. In this case the school district paid the cost of the ointments. As you know, these small schools are usually made up of four or five families; therefore, it was not difficult for the nurse to make the necessary home visits to teach the mother how to carry out the treatment for impetigo and scabies."

If this is not diagnosing and treating disease and thus practicing medicine, what is it?

Educated licensed physicians do not always find it so easy to make a correct diagnosis of all itching skin eruptions, nor do they all take chances with ammoniated mercurial ointment when the diagnosis is uncertain. Sulphur ointment has the virtue that it is harmless.

All worthwhile physicians fully appreciate the tremendous value of public health nursing, and they have the greatest admiration for the splendid work the vast majority of these women are doing. Doctors, better than others, realize the personal sacrifices that the pioneers in this comparatively new service are making, and always extend the hand of helpfulness and encouragement to these nurses.

Physicians do feel that public health nurses have enough to do in this broad and hardly explored field in which they have been educated and trained to serve, without attempting to diagnose and treat disease.

Compensation Insurance Fund Pays Dividend—The Industrial Accident Commission has authorized the return of an average of 30 per cent of the premiums collected from policy-holders during the year 1924. The dividend for the current year reflects a successful conduct of the fund that is shared in by its patrons. Notices of return premium will go out about January 1, 1925. During its existence, extending over a period of eleven years, the fund has returned to its policy-holders $8,300,000.

This year's volume of business is the largest in the fund's history.

Telephone Amenities and Otherwise—An editorial under the above caption in Northwest Medicine, November, 1924, evidently struck a responsive cord in the hearts of several of our readers. The closing paragraph of the editorial reads:

"If anyone is to be kept waiting at the telephone, the one who calls should do it and not the one who receives the call. It might be well if physicians would bear in mind that good manners will be better served if they will allow their attendants to ring up others only after they themselves are ready to answer. Or, better still, as soon as the other fellow's attendant has indicated that he is on hand to take the telephone, and themselves do whatever waiting is necessary."

Some Things the Mail Man Brings Doctors—One of our members dropped into the editorial office the other day and handed us the odds and ends of the things that had come to him through the United States mails recently.

We note the following abstracts:

Case 1—*Called a West Union Tel-Gram*—"Long Beach, Calif. Many doctors and 80 to 90 per cent of the patients treated with concentrated orchitic solution—goat, ram or monkey type—have decreed that your interest should be eminent. Return this Tel-Gram, designating quantity desired of Concentrated Orchitic Solution—goat type, ram type, monkey type."

Case 2—*Form Letter on the Stationery of an M. D.*—"Mr. —— suffered a hemiplegia of the left side, January 13, 1924, and the doctors there said nothing would do any good. April 16, I gave him 20 cc. more of the Concentrated Orchitic Solution. Today, April 19, his blood pressure is normal and he is very much improved. Walking without his cane."

Case 3—Was an announcement to the effect that the chiropractors were going into politics!!?

Case 4—A "Catechism of the Electronic Methods of Dr. Albert Abrams."

Case 5—An invitation from ——, A. M., M. D., on stationery of "The Birth Control Clinical Research," to send $1 for "Birth Control Methods."

Case 6—A. D. O., M. D., announces the removal of his offices and invites his friends to a two-day pre-view of his new offices.

Case 7—Announces the opening of the —— Laboratories "Under Medical Supervision."

Case 8—Letter inviting purchase of lottery tickets. (Letter forwarded to postoffice authorities.)

Case 9— —— Foundation Clinic. They want to cooperate with doctors."

Case 10—A "personal puffery" bulletin of the type now issued by certain hospitals, health centers, clinics and individual physicians, telling other doctors all about me and my methods.

Case 11—An invitation to buy "six essays on sex" and "How and why we are made."

Cases 12, 13, and 14—Advice about investments and urgent invitatians to buy—and—and—

Some Day We Will Meet Here—Maybe—What, if any, common ground is there for the physician, the health officer, and the layman to meet upon? This has been a cause for much discussion, and apparently a partial answer may be found in periodic medical examination of the apparently healthy person. This is a field in which the health officer can preach the lowering of morbidity and mortality rates; the health enthusiast picture a perfect future race; the physician exercise his diagnostic technique and develop along therapeutic lines; and the average citizen, the apparently healthy person, participate with reasonable expectation of a fair return for the effort.

The health officer has been mainly active in mass health promotion and protection; the physician steeped in disease diagnosis and treatment; the layman interested in his pains and symptoms. *All must become adjusted to personal medicine—the health officer as the promoter, the physician as the guide, and the layman as the willing seeker after health.*

"The private physician is more or less familiar with the patient's interests and environment and, therefore, better able to render health service to the individual than is the case when the examinee comes as a stranger to a strange physician. This is important—the success of the health examination depends more upon the rapport between physician and examinee than does a diagnostic examination."

"The medical technique used in making health examinations differs in no essential from that of any thorough physical examination. The points of view of physician and examinee and their attitude toward the examination, are, however, essentially different from the usual relationship between physician and patient."—A. N. Thompson (The Commonwealth).

A Microscopic Study of Mercury Absorption From the Skin—Microscopic examination made by Karl G. Zwick, Cincinnati (Journal A. M. A., December 6, 1924), of intact animal skin, to which mercury, in the form of mercurial ointment had been applied by inunction, established: 1. The presence of globules of mercury: (a) in the infundibula of the pilosebaceous follicles; (b) in the orifices and excretory ducts of the sebaceous glands. 2. The absence of globules of mercury: (a) in the intact epidermal layers that are not constituents of the integumentary appendages: (b) in the cutis vera. Microscopic findings lead Zwick to conclude that: 1. Percutaneous absorption of mercury, following inunction of animals with mercurial ointment, takes place preponderatingly from the material deposited in the pores, consisting of the orifices of the hair follicles and of the excretory ducts of the sebaceous glands. 2. Percutaneous absorption of mercury is not materially influenced by removing from the intact skin the excess of mercurial ointment deposited on it during inunction, because mercury does not penetrate into or through the intact epidermis.

MEDICAL STRAWS

By THE EDITOR

Experience is fallacious and judgment difficult

Professional Pitfalls—The Council of the Union (a British medical defense organization) states that the number of cases (malpractice) with which it dealt has increased and that there is reason to believe that charges against medical practitioners are becoming more frequent, possibly because certain actions lately heard in the High Court have encouraged patients to seek to obtain damages from their medical attendants when recovery has been more prolonged or less complete than they imagine it should have been.

Federal Government Wants More Salaried Doctors—They want them of the Grade A and Grade B classes, and they propose to pay them from $1680 to 3000 a year. In order to make these remarkable salaries still more intriguing they offer maintenance in some of the least desirable of the positions.

The Gamest Guy in the World (Meigs O. Frost, Collier's), is a beautifully told story of fortitude, patriotism and medical service that bristles with morals and statements for exhausted SERVICE batteries.

THAT there is an ebb and flow in the tide of syphilitic morbidity should always be taken into account by those who are studying morbidity rates of venereal disease, and especially by public health officers who are attempting to arrive at conclusions regarding the value of laws compelling the reporting of these diseases.

Too many vital statisticians are losing track of the tides, in frantic efforts to measure individual waves.

The Doctors We Patronize—The examining physician of the Y. W. C. A. in Pasadena reports that, in examining 1200 women and girls, she asked them the names of their attending physicians. Seven hundred and seventy-two of these young women patronized osteopaths; 120, chiropractors; 183 christian scientists, and 125 educated physicians.

Is this a logical consequence of our several years of "health education" for everyone?

Who Are "We"?—"Shall the nurse perform vaccinations or immunizations?" asks J. J. Sippy, M. D. (Pacific Coast Journal of Nursing) and then, answering the question, says: "Without authorization, no. But as far as actual technique is concerned, WE are most of us willing to admit that *she is usually as capable as the physician.* (Italics ours.) It has seemed somewhat contradictory to me that many physicians will entrust the care of serious wound infections to their office nurses and yet resent the performance of a smallpox vaccination by the public health nurse."

"Yellow Medical Journalism"—Doctors are still neonates in the field of popular journalism, and already some writers are calling them "Princes among yellow journalists."

It is said that some doctor writers, with more newspaper notoriety than professional reputation among their colleagues, are occupying the field of flambuoyancy, the spectacular and the personal bombast now all but vacated by the patent food, patent medicine, and "get-rich-quick Wallingford" fakirs.

How much truth is there in this charge?

Osler Said Cannily—"It is more important to know *what kind of a patient* has pneumonia than it is to know *what kind* of pneumonia the patient has."

A New Spirit in Health Work—A writer, in a recent issue of the State Board of Health official publication, says:

"Concerted effort is needed to correct the false impression that is prevalent in some sections of this state that the public health nurse is violating the Medical Practice Act by making diagnoses and treating disease. Wherever wilful misrepresentation is made, and where false charges are brought, *vigorous retaliation should follow.*"

Several Departments of Government Still Advertising for More Doctors—The Public Health Service; the Indian Service; the Coast and Geodetic Service; the Panama Canal Service; and the Veterans' Bureau are all advertising for more doctors. The opening salaries (?) offered are from $140 to $250 per month. Those interested should address the United States Civil Service Commission at Washington.

Regents of University of California Uphold Scientific Medicine—Protection against smallpox by vaccination is still one of the *requisites* of students at the University of California. The strenuous campaign of certain internists to change the *"requirement"* to an *"optional"* failed. It is said that the only regents who voted for the backward step were the Governor of California, Chairman of the Board, and J. O. Hayes from San Jose, appointed regent by Governor Richardson.

The Things That Count—In the every-day work of medical practice, as in the world of business, the qualities of absolute honesty, integrity, and consistent industry are far more important than brilliance of intellect or flashes of genius, valuable and stimulating as are these latter traits.—E. J. G. Beardsley, Journal New Jersey Medical Society.

Prevention and Cure—One official state health bulletin now boldly places in prominent headlines its program of public health betterment to include *Prevention and Cure.*

Heretofore, all official health bodies have denied their intention to include the practice of personal medicine as part of the public health medicine program.

Fewer and Better Books—"A plea for fewer and better books was applauded at the annual convention of the American Booksellers' Association," says The Nation's Business. "Too many 'pot boilers' are coming from the printing houses, to the discouragement of book reading and book owning."

This should apply and must apply to the medical books. Why not eliminate some of the medical "pot boilers" at least?

Why Do Doctors Assist Laymen in the Practice of Medicine?—Medical men probably never will overcome the dabbling of lay persons in purely medical problems, but we can put a crimp in such activities by refusing to have anything to do with them. Medical problems should be solved by medical men without the intervention of lay persons who interest themselves for commercial reasons or to exploit themselves.—Journal of the Indiana State Medical Association.

Sauce for the Goose

—Physicians receive bills the first of every month from everyone to whom they owe money. . . .

—A doctor's worst enemies, and the ones most apt to speak ill of him or even give him trouble without cause are the persons who owe him money and can pay but will not, and some of the charity patients who long have been accustomed to dependency, are not ashamed to ask for assistance and are very exacting.

—If the doctor's services are donated, the patient should understand that they are being donated and that he is accepting charity.—Lovett Morse.